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ABSTRACT

This curriculum was designed to train approximately 250 community health representatives (CHRs), to teach visually impaired and blind Indian elders and their families necessary independent living skills. The curriculum aims to sensitize CHRs to the impact of visual impairment upon elderly persons and their families, and to provide basic information regarding vision problems, consequences of those problems (particularly within Indian cultures), and methods and resources that may be used to provide rehabilitation to the visually impaired elderly. The curriculum is implemented during a 5-day training program in which the following seven modules of academic and practical rehabilitation understandings and skills are covered: (1) Introduction to Rehabilitation (including adult learning); (2) Understanding Blindness and Low Vision; (3) Psychosocial Aspects of Aging and Vision Loss; (4) Walking in a Familiar Environment (sighted guide and other safety techniques); (5) Daily Living Skills; (6) Adapted Recreation and Leisure Activities; and (7) Resources and Advocacy Skills. Each module includes objectives and expected outcomes of the learning experience, basic content, necessary materials, and selected reinforcement activities. Appendices contain a training agenda, suggested readings, key words, various forms and assessments used in training, and lists of resources. (KS)

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A TRAINING MODEL TO TEACH COMMUNITY OUTREACH WORKERS TO TRAIN ELDERLY BLIND AND VISUALLY IMPAIRED AMERICAN INDIANS INDEPENDENT LIVING SKILLS: FOCUS ON FAMILY REHABILITATION

The Seven Module Curriculum on Aging, Vision Loss and Independent Living Skills

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INTRODUCTION

Background

The population of those persons over the age of 60 is increasing dramatically. The population of those over the age of 85 are expanding most rapidly. Sensory loss (both vision loss and hearing impairment) affects the lives of most of those who are living longer. The fields of blindness and aging are confronted with growing numbers of older persons in need of a vast array of services from both the aging and the blindness service delivery systems. The same is true for health care and social service providers of other professional disciplines. Yet many service providers feel unprepared to serve persons who are visually impaired because of a limited knowledge base in blindness and the area of aging and blindness, and because they lack the skills to assist or even effectivelty interact with blind and visually impaired clients.

In the 1990's more than 3 million severely visually impaired older persons experience multidimensional service needs because of the range of physical and psychological factors confronting the older person who is experiencing vision loss. Visual impairment, unlike some of the commonly considered life-threatening conditions such as heart disease, stroke, or the devastating effects of Alzheimer's Disease, is not life-threatening yet it affects the quality of life. Visual Impairment effects both physical and psychological independence, an intangible quality valued highly by people at this stage of the life cycle.

In 1977, it was projected that by the year 2000 the number of older persons with a severe visual impairment would have increased from 990,000 to 1,760,000 (Kirchner, 1985). Yet statistics gathered in 1984 by the National Health Interview Survey and released in 1987 by the National Center for Health Statistics (NCHS) estimated that 2,038,000 elderly persons were severely visually impaired. The year 2000, then, has already arrived, presenting the fields of blindness and aging, health and family caregivers with an unexpected number of older people needing a myriad of services due to varying degrees of vision loss. Data also indicates that among every 1,000 elderly persons almost 78 are severely visually impaired, an increase of approximately 74 percent over that estimated in the 1977 statistics.

The 2,038,000 severely visually impaired older persons represent 8 percent of the community-based elderly population. This number is considered to be a conservative estimate of the actual number of severely visually impaired older persons because of difficulties of data collection. Among nursing home residents 3 percent have no vision at all, with another 26 percent partially sighted or severely visually impaired (having some usable remaining vision).

Sixty-six percent of the general population of older persons who are severely visually impaired live in their own homes in the community, independently, or with varying degrees of assistance and support services from family members and other non-paid caregivers, as well as professional service providers. Sixty-six percent of older persons who are visually impaired also have at least one other chronically disabling condition such as arthritis, hypertension, arteriosclerosis and hearing impairment (Blake, 1984).

The Problem

According to the National Indian Council on Aging (1986), the number of American Indians 60 years of age and over is increasing dramatically with a 1970 census count of 64,000 over the age of 60, 109,000 over 60 in 1980, and a projected 200,000 by 1990. The National Congress of American Indians in 1986 reported that the 200,000 projection for 1990 had already been reached that year, with the population of elderly American Indians continuing to increase at a rapid rate.

Elderly persons representing minority groups including blacks, Hispanics and American Indians are more vulnerable to vision problems throughout their lives and have higher proportions of vision loss among the elderly than the overall elderly population. Forty-two of every 1000 white elderly persons are severely visually impaired, compared to 71 out of every 1000 non-white elderly persons (AFB, 1982).

The statistics document the need for greater knowledge and understanding of older visually impaired persons, of the problems of vision loss, and the need for professionals across disciplines who work with older people to be increasingly prepared to plan for and provide services to this growing population.

The incidence of visual impairment and blindness among American Indians is higher than that in the general population because of the high incidence of diabetes, a leading cause of blindness. (The five leading causes of blindness among persons over 55 in the country include macular degeneration, cataracts, diabetic retinopathy, glaucoma and optic atrophy.) Among Native Americans diabetic retinopathy is the most highly reported eye condition, with the incidence of cataracts and glaucoma apparent as well. Macular degeneration, however, seems to have a lower incidence among American Indians than in the general population.

Next to the abuse of alcohol and alcoholism, diabetes is the number one health problem among American Indians. In most tribes diabetes has reached epidemic proportions. One in every three American Indians is at risk of developing Type II (non-insulin dependent) diabetes (Brosseau, Bata, and Marquart, 1984). Seven percent of all Native Americans in the country between the ages of 20 and 74 are diabetic and at risk of developing diabetic retinopathy (National Diabetes Data Group, 1985). Among the Pima Indians, for example, Armstrong (1985) reports that 45 percent of males 45-74 years of age and 65 percent of females between the ages of 55 and 64, are diabetic and visually impaired as a result of diabetic retinopathy. Dr. Terry Sloan, the Aberdeen area coordinator for the Indian Health Service, reported (during his presentation at the Fifth Community Health Representative(CHR) Training Session of the American

Foundation for the Blind in Bismarck, North Dakota, August 8, 1988) that 29-30 percent of American Indians in the Aberdeen area are diabetic.

Aston (1984) reports that 13.5 percent of all elderly American Indians 55-64 were visually impaired due to diabetic retinopathy, the highest percentage among five eye diseases (conjunctivitis, cataracts, diabetes, macular degeneration and glaucoma), and that 8.2 percent of elderly American Indians between the ages of 65-71 had diabetic retinopathy.

Blindness or visual impairment among the elderly can have a devastating impact on their lives. For example, it can lead to both physical and psychological isolation, to a decrease or cessation of involvement and participation in daily living activities, to a loss of independent mobility and physical freedom and a loss of self-confidence, self-worth and self-esteem.

What can be done?

Rehabilitation Status

Rehabilitation services and low vision services can make a major difference in the life of older persons who are gradually losing their vision, who are experiencing severe visual impairment, or who are already blind. But these rehabilitation services must be accessible and responsive to the needs of older visually impaired persons in general, and to specific populations of elderly visually impaired persons such as elderly Hispanics and Native Americans who, for language and cultural differences, experience barriers to accessibility.

Historically, rehabilitation services have not been easily available for the general population of blind and visually impaired elderly persons because the major focus in the field of blind rehabilitation has been on vocational rehabilitation for remunerative employment. The concept of rehabilitation for independent living has not been widely accepted. Only as recently as 1986 has Congress recognized the rehabilitation needs of elderly blind and visually impaired persons by funding legislation for this population. Title VII-Part C (Community-based Independent Living Services for Older Visually Impaired Persons) was enacted at the time of the reauthorization of the Rehabilitation Act in 1978. However, Title VII-Part C was not funded until 1986. That year twenty-five grants of $200,000 each were allocated to 24 states. The purpose of Title VII-Part C is to provide community-based independent living skills training to older blind and visually impaired elderly in order to enable them to function as indepen-dently as possible in their own homes and communities, and to prevent premature and costly institutionalization. In 1990 only 28 of the 50 states have Title VII-Part C funds because of the limited pool of funds at the federal level.

The service delivery to hard-to-reach populations is even more limited. As is too often the case, if no specific mandate is made to serve a particular population such as a minority group or rural population, little or no targeted outreach is carried out on the part of service providers to address the needs of the special group. This is true for the population of elderly American Indians who are losing their vision at a higher rate than the general population. While the community-based rehabilitation services are generally "available to everyone", American Indians have limited knowledge of such services and typically feel that these services are not accessible to them and that they are not eligible for them. Language, cultural barriers and geography contribute to the lack of, or limited access to, rehabilitation services for elderly American Indians and their families.

Lack of access to rehabilitation services may lead to premature institutionalization for those who have no family care. At the time of the conceptualization of this project there were eight nursing homes with 492 beds on reservations for American Indian elders. Given the steadily growing number of elderly in our population and the increasing prevalence of visual impairment and blindness in the overall population of those over 55, there is a need for elderly blind and visually impaired persons to learn critical adapted daily living skills training through rehabilitation services in order to insure their ability to continue to live as fully as they wish in their own communities. The same need holds true for the population of elderly American Indians.

A review of the literature reveals a dearth of information regarding rehabilitation services for this population. At the time the proposal was written to initiate this project there was not even a computerized count of the number of eyeglasses dispensed by the Indian Health Service to American Indians for a given year.

In summary, given the high incidence of diabetes among Native Americans and the apparent lack of access to vision rehabilitation services, the American Indian Rehabilitation Project was initiated by the American Foundation for the Blind (AFB) to teach CHRs and to train trainers to teach CHRs about aging and vision loss and independent living skills to assist elders.

The American Indian Rehabilitation Project

Due to the lack of hard data, but knowing that older American Indians were experiencing vision loss through professional contacts with Native American leaders, the American Foundation for the Blind recognized the need to address this problem. Through the Chairperson of the Oklahoma Indian Council on Aging, Elderly Program for the Creek Nation in Okmulgee, Oklahoma, American Foundation for the Blind staff, including two national consultants on aging, the Regional Consultants in the Southwest and Western regions in particular, and the Governmental Relations Specialists met with representatives from national Indian organizations to determine more fully the extent of the need for rehabilitation services among elderly American Indians and the role of the American Foundation for the Blind in helping to meet this need. Specifically, the Foundation's staff met with national representatives, including Curtis Cook, Executive Director, National Indian Council on Aging; Karen Funk, National Congress of American Indians; Jake Whitecrow, Director, National Indian Health Board; Nicki Solomon, Director of Community Health Representatives, Indian Health Service; Betty White, Chairperson, National Association of Title VI Grantees, Yakima Indian Nation, and Steve Wilson, Chairperson of the Oklahoma Indian Council on Aging, Elderly Program for the Creek Nation to plan for service delivery.

The conceptualization of this project grew out of the history of collaboration between the American Foundation for the Blind and a number of Indian tribes in the West and Southwest on similar programs. Most significantly, one of the Foundation's national consultants on aging was invited to conduct a one-day training program for the Directors of Title VI programs in Okmulgee, Oklahoma to identify vision-related services and rehabilitation services available to elderly Creek Indians. When the participants became aware of the potential of such training toward the growth of Indian Health Service workers working directly with elderly Native Americans, they expressed interest in future training sessions.

Other American Foundation for the Blind staff working closely with Native Americans include Corinne Kirchner, the

Director of AFB's Social Research Department who directs a project funded by the National Institute of Disability and Rehabilitation Research entitled "Assessing and Addressing the Needs of Blind and Visually Impaired Populations on the Hopi Reservation: Qualitative and Quantitative Data Collection and Development of Training Materials".

The Regional Consultants of the American Foundation for the Blind have also worked with representatives of the Four Corners Area (Colorado, New Mexico, Utah and Arizona), including leaders from the Indian Nations as well as from the field of blindness, to identify gaps in service as well as the needs of older visually impaired Indians in this four-state area.

The consensus among the representatives of national Indian organizations and programs in the country was that:

1) there is a large number of unserved and underserved blind and visually impaired American Indians in this country,
2) there is a high percentage of diabetes among elderly American Indians at risk of developing diabetic retinopathy,
3) the American Indian elderly population has no clear access to existing rehabilitation services in their region due to language, cultural and geographical barriers to such services,
4) American Indians will not seek the services because a)

they are unaware of them, b) they feel the services are not theirs to have for various reasons, c) services are available only through Anglo workers, in addition to the fact that there are system-wide gaps in service based on geography and economics,

5) in order for this population to learn about and take advantage of rehabilitation services, the service providers must be indigenous,

6) professional trainers from the blindness field are needed to train Community Health Representatives to teach older visually impaired and blind American Indians independent living skills and adaptive techniques to carry out activities of daily living,

7) Indian Health Service trainers must also be trained by blindness professionals so that they can continue to teach additional CHRs,

8) the rehabilitation process must focus not only on the elderly blind and visually impaired American Indians but also on their family members in order for successful rehabilitation to take place,

9) the professional staff of the American Foundation for the Blind had the skills to provide training on aging, vision loss and independent living skills to the Community Health Representatives.

A population of American Indian workers with regular access to elderly American Indians would be best suited to serve this function, i.e. Community Health Representatives (CHRs) because:

a) they are usually indigenous and, therefore, knowledgeable of the client's orientation, receptivity, tribal culture and language

b) they have basic knowledge of health care and could learn to detect the early signs of vision loss

c) they are the primary link between the elderly Indian and health care settings such as clinics or nutrition sites, both on reservations and in the community

d) they are recognized, established, trusted groups of paraprofessionals with regular, in-service training programs into which content on aging and vision loss could eventually be infused.

Goals and Objectives

The goal of the project was to design a seven module model curriculum on aging and vision loss and independent living skills training; to train approximately 250 Community Health Representatives who, in turn, could teach elderly blind and visually impaired American Indians and their families the necessary independent living skills to enable them to remain as independent and as active as they wished in their own homes and community, both on and off the reservation and to continue involvement in tribal life, and, to prevent premature and costly institutionalization.

In Phase II of the project a "Train the Trainers" component was conducted.

The objectives of this project were:

1. to develop a five-day, seven module model curriculum for training CHRs, which would be used for further trainings carried out by AFB trained trainers,
2. to train approximately 250 CHRs representing as many tribes as were interested at seven separate training sessions, approximately 40 trainees per session, at the following sites: Tulsa, Oklahoma; Albuquerque, New Mexico; San Francisco, California; a second training in Albuquerque; and Bismarck, North Dakota, Tucson, Arizons and Portland, Oregon.
3. to evaluate the outcomes of the training sessions by assessing the extent to which CHRs were utilizing the information and skills learned during the course of the training, and
4. to disseminate the findings of the training and the model curriculum to the blindness, aging and Native American service delivery systems.

This project is the first national initiative to make services available through the blindness system more accessible to blind and visually impaired American Indians in general, but specifically to elderly blind and visually impaired American Indians.

THE CURRICULUM

The curriculum has been prepared to train community health representatives and to train trainers to prepare Community Health Representatives to serve visually impaired and blind Indian elders. The American Indian trainers who will use the curriculum to conduct future training sessions under the auspice of the Indian Health Service will lend the cultural underpinnings to make it most relevant to CHRs and to elders. The curriculum may be adapted for use with other minority groups for whom language and culture create differences which may limit access to rehabilitation services.

Goals and Objectives

The goal of the curriculum is to sensitize trainers and CHRs to the impact of visual impairment upon elderly persons and their families, to identify visual impairment, and to provide basic information regarding vision problems, the consequences of those problems and the methods, materials and resources which may be used to provide rehabilitation to the visually impaired elderly. More specifically, the objectives are:

1. To introduce trainers and CHRs to the concept of rehabilitating visually impaired elderly for independent living.
2. To describe the four leading causes of visual impairment among the elderly with a special emphasis on diabetic retinopathy

3. To explore the impact of visual impairment upon the individual, significant others, and the resulting effect upon relationships within Indian culture.
4. To introduce the concept of low vision.
5. To identify the unique characteristics and needs of elderly persons as learners.
6. To provide both academic information about, and hands-on practice with, methods and materials used in orientation and mobility and rehabilitation teaching services.
7. To identify local, state and national services.
8. To describe methods of advocacy in seeking services.

The objectives of the curriculum will be achieved by establishing a 5-day training program in which seven modules of both academic and practical rehabilitation understandings and skills will be offered. The curriculum consists of the following modules:

1. Introduction to Rehabilitation and Adult Learning
2. Understanding Blindness and Low Vision
3. Walking in a Familiar Environment (Sighted Guide and other Safety Techniques)
4. Psychosocial Aspects of Aging and Vision Loss
5. Daily Living Skills
6. Adapted Techniques for Recreation, Cultural and Traditional Indian Activities.
7. Knowledge of Resources and Advocacy Skills

The curriculum is presented module-by-module, each of which includes the *objective* and *expected outcomes* of the learning experience, basic content, necessary materials, and selected reinforcement activities. A sample of a 5-day agenda will be found in the Appendix, as will suggested readings and materials for each module.

MODULE I - INTRODUCTION TO REHABILITATION

Objectives

1. To define the meaning of rehabilitation and to identify its elements.
2. To explore how rehabilitation can enhance the lives of elderly Indians and their families.
3. To describe the rehabilitation process and the settings in which it can be provided and how independent living skills training can be provided on the reservation.
4. To describe the unique characteristics of the older person as a rehabilitation client and as a learner.

Expected Outcomes

1. The trainees will define the concept of rehabilitation.
2. The trainees will be able to describe the rehabilitation process.
3. The trainees will be familiar with the common settings in which rehabilitation is provided, and how they will bring rehabilitation to elders.
4. The trainees will be able to describe six characteristics which may be unique to the elderly client as a rehabilitation candidate.

Rehabilitation defined

Rehabilitation is the process which assists an individual with an impairment to make use of his/her personal and environmental resources so as to achieve his/her potential for personal contentment and social integration.

The World Health Organization's Classification System on Impairment, Disability and Handicaps provides the following definitions of impairment, disability and handicap.

> Impairment is any loss or abnormality of anatomic structure or physiological or psychological function at the organ level. When the degree of functional limitation is sufficient, the difficulty or inability to perform daily living activity leads to disability.
>
> Disability occurs at the person level and represents any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a person of the same age, culture and education.
>
> Handicap occurs at the societal level when conditions are imposed upon the person in such a way, through disadvantageous social norms and policy, that limits the individual in fulfillment of expected social roles.[1]
>
> The goal of rehabilitation is to prevent an impairment from becoming a handicap.

---

[1] Abdellah, Faye G., "Public Health Aspects of Rehabilitation of the Aged", in Brody, S. J. et al, Aging & Rehabilitation, Springer, NY, 1986, p. 50.

REHABILITATION is a relatively recent concept. Two models of helping exist.

The Medical Model is concerned with curative aspects of a disease--not necessarily with management of the consequences that is, making the patient as "well" as possible but not necessarily attending to resulting lack of function.

The Rehabilitation Model is concerned with function, that is, the client's ability to manage his/her life as comfortably and as effectively as possible.

Elements of rehabilitation include:

1. Prevention (nutrition, safety, activity, stress reduction, etc.)
2. Restoration (medical/surgical procedures, prosthetic devices, etc.)
3. Maintenance (compliance with prescribed medications, activities, diet, etc.)
4. Learning (knowledge of condition, use of aids/devices, new ways of doing activities, etc.)
5. Environmental Modification (architectural, lighting, furnishings, personnel, etc.)

These elements can all to made relevant to Indian life on and off the reservation.

In the 1940's rehabilitation was spurred on by the needs of polio victims and World War II veterans.

The goal of rehabilitation was employment.

Rehabilitation in the 1950's included civilians, but employment still was the goal.

INDEPENDENT LIVING, as a goal, developed during the 1960's and '70's.

Independent living initially focused on the young disabled population.

Elderly visually impaired persons have only recently become eligible for federally funded rehabilitation services within the concept of independent living. This began in 1986 with the passage of Title VII-Part C, part of the amendments to the Rehabilitation Act of 1973. Part C of Title VII calls for community-based independent living skills training for blind and visually impaired elderly persons. Services are provided through public and private agencies for the blind. Title VII Part C services are primarily provided in the home of the older person.

The specialists in the field of blindness include:

1. Rehabilitation Teachers who teach blind and visually impaired persons the basic skills of daily living: personal management, communications, home management, and leisure time activities.
2. Orientation and Mobility Instructors who teach blind and visually impaired persons to be oriented to their

physical environment effectively in the indoor and outdoor environment. Orientation and Mobility instructors teach blind persons the use of the white cane.

3. Optometrists (O.D.) who test the eyes for defects in vision for the purpose of prescribing corrective lenses.
4. ophthalmologists (M.D. or D.O.) who treat diseases of the eye, perform eye surgery and prescribe medication/ corrective lenses for the eye.
5. low vision trainers who teach persons with usable vision to make more efficient use of vision with, or without, the use of low vision aids or devices.

Additional members of the rehabilitation team include:

6. Occupational Therapists
7. Physical Therapists
8. Social Workers
9. Psychologists
10. Recreation Therapists
11. Gerontologists
12. Teachers
13. Nurses
14. Nutritionists

Rehabilitation requires a team effort for comprehensive and wholestic rehabilitation to take place.

Rehabilitation begins with an assessment of the client in the following areas:

1. Functional Skills in daily living
    - .Personal management
    - .Orientation and movement
    - .Food preparation
    - .Home maintenance
    - .Communication skills--written/oral
    - .Clothing care
    - .Recreation
2. The Support System
    - Family members
    - Significant others
    - Health personnel
3. Personal and other persons' attitudes toward, and understanding of, the eye condition

The rehabilitation teacher must:

- .Listen to the client with regard to life circumstances, abilities, needs.
- .Determine primary needs, with client participation
- .Begin where the client is, i.e., begin working with the client by starting the teaching with what the client wants to learn.

The key to rehabilitation is sensitivity to the client:

- .What does he/she need and want?

.What are his/her expectations and understandings of what is to be gained from rehabilitation?

.What supports exist for successful rehabilitation?

.What are the rewards for the client's efforts?

.What are the costs to the client in this effort both economically and personally?

To learn about the client the rehabilitation teacher must:

.Observe

.Listen to the client/family/professionals

.Use appropriate interviewing skills to gain information while at the same time putting the client at ease.

The Older Person As a Learner

The older person as a learner may differ from the traditional learner in some or all of the following characteristics:

1. The older person may freely accept or reject the opportunity to learn new skills
2. The older person is particularly affected by other possible losses (physical, familiar, economic, etc.) which occur with great frequency at this stage of the life cycle.)
3. They focus heavily on current needs
4. They may fear failure more than younger persons or looking foolish or making mistakes.
5. They may demonstrate slower reaction time

6. Older persons may have well-established patterns of behavior and tastes or receptivity to change
7. Some may have a low energy level
8. Some may hesitate to invest in new endeavors, "I'm too old."
9. Many experience other sensory losses, particularly hearing loss concurrently.
10. Some may require a little more time to recall information.

It is important to note, of course, that some elders may not experience or demonstrate any of these characteristics.

Principles of Instructing the Older Learner

Because of some of the above experiences, the following principles of instruction should be followed:

1. Plan with the learner; be consistent with his/her interests/needs in learning.
2. Teach in relation to the experience of the learner, making associations with life experiences and prior learnings, in this case particularly as they relate to cultural and traditional Indian activities
3. Use terminology he/she understands
4. Speak clearly; do not shout
5. Let the learner set the pace of the activity or skill to be learned

6. Attempt to reduce distractions in the environment
7. Use multi-media methods which allow for learning in several ways.
8. Keep lessons brief/interesting/meaningful/relevant to cultural life.
9. Move from less difficult to more difficult subject matter, building on knowledge and skill acquisition.
10. Teach correctly the first time.
11. Teach in a manner which assures the success of the learner.

To enhance learning consider the following:

1. Take particular note of the learning environment lighting/temperature/acoustics to make it maximally functional.
2. Where possible provide the client with comfortable seating--easy to get into and out of
3. write in large print or tape instructions and key information, which ever is most useful for the client.

Rules for teaching daily living skills

1. Have a logical, clear work plan
2. Gather all materials before starting
3. Show the learner where materials are and ascertain that he/she can locate them easily during the learning activity

4. Teach the learner to use each item correctly and safely
5. Keep in mind that "contact" (touch) is a key element in instructing visually impaired/blind persons
6. When the lesson is finished, the learner should clean up and replace equipment to appropriate place where it can be located most easily the next time needed.

If the learner has a hearing problem:

1. The speaker should face the learner
2. Light should be on the speaker's face
3. Speaker should not cover his/her mouth
4. Speaker will not have food/cigarette in mouth
5. Speak clearly
6. Do not use excessive bodily movements; they distract the learner
7. If the learner cannot understand, use different words to provide the same information or instruction.
8. Let the learner manipulate the environment to establish maximum hearing
9. If using group discussion, tell the learner the topic of discussion
10. If relevant, speak to the learner's better ear

If learner has problems with memory:

1. Keep list of daily chores
2. Do important things first
3. Write/tape names, dates, appointments, instructions, lists, etc.

4. Place phone numbers and other important information in various key locations
5. Allow more time for recall of information
6. Develop personal systems of making relationships, i.e. names/faces, etc.
7. Ask professional helpers to write/tape important information

Module Summary

Learning Activities

Large Group Discussion

Trainees will discuss their professional experiences to date with visually impaired or blind clients and tell about any services for the blind they know. They will have an opportunity to express their reactions to the training agenda, and their special needs and interests related specifically to their job assignments and caseloads.

Film: What Do You Do When You See a Blind Person?

This 17-minute film highlights the most common misunderstandings among the general population about visual impairment and blindness and about blind and visually impaired people. The film is light and humorous and can get the audience comfortable in dealing with the content of the curriculum.

CHR Information Form: Have trainees complete this form

Pre-Training Attitude Form: Have trainees complete this instrument

Reading Materials: Distribute appropriate reading materials related to Models I or II

MODULE II - UNDERSTANDING BLINDNESS AND LOW VISION

Objectives

1. To identify and describe the most common eye diseases among elderly people, particularly elderly American Indians.
2. To become familiar with the concepts of legal blindness and low vision.
3. To recognize the signs that a vision problem may be present.
4. To become familiar with low vision resources.
5. To become familiar with non-optical assistance for persons with low vision.

Expected Outcomes

1. Trainees will be able to name four leading causes of vision impairment.
2. Trainees will be able to describe the functional implications of each condition.
3. Trainees will be able to define: legal blindness, low vision, optical aid, non-optical aid.
4. Trainees will be able to name eight ways in which to enhance low vision.
5. Trainees will identify three resources available to them which will be of assistance to a visually impaired client.

Legal blindness defined

Legal blindness is defined as the visual acuity of 20/200 or less, in better eye, with the best correction, or a visual field of no more than 20 degrees. 20/200 means that one sees at 20 feet, on the eye chart, what "normal" vision sees at 200 feet. Legal blindness may range from the ability to read newsprint to no vision at all.

Low vision defined:

Low vision is described as a vision loss that is severe enough to impede performance of everyday tasks but still allows some useful visual discrimination. The category of low vision covers a broad range from mild to severe visual loss but excludes those who have a full loss of functional vision.

Observable behaviors in an adult which may indicate a vision problem:

1. Consistently bumps into objects.
2. Ascends or descends stairs slowly and has no other physical limitations.
3. Has difficulty walking on irregular or bumpy surfaces.
4. Has difficulty naming colors or makes unusual color combinations in the selection of clothing, for example.
5. Has difficulty identifying faces from a distance.
6. Holds reading material very close to, or far from, face, or at an angle.
7. Cannot read mail or newspaper.

Light is scattered by the opacity, and creates glare. Wet surface at night, in bright light, is particularly dangerous.

Treatment: eye glasses, contact lenses, implants, following surgery.

2. Glaucoma - internal damage to eye caused by increased pressure within the eye

   Loss of peripheral vision

   Difficulty focusing

   Blurred vision

   Slow adaptation to dark

   Treatment: controlled by medication or surgery

3. Macular degeneration (age-related maculopathy)

   Progressive, irreversible damage to the macula (part of retina)

   Gradual loss of fine, reading vision

   Treatment: lasers, in some cases, halt degeneration

4. Diabetic retinopathy - a disorder of blood vessels in the retina--associated with diabetes

   Blurred vision

   Blocked vision

   Exacerbation/remission

   Treatment: laser

Low vision clinics serve persons with low vision

Staffed by: optometrists, ophthalmologists, vision trainers,

8. Has poor handwriting, develops poor handwriting, or has difficulty "staying on the line".
9. Demonstrates sudden change or unusual behavior patterns involving reading, watching television, driving, walking or hobbies, or stops doing these activities.
10. Reaches out for objects in an uncertain manner.
11. Has difficulty locating personal objects in a familiar environment.
12. Requests additional lighting or says the lighting is insufficient.
13. Squints or tilts head to the side to see.
14. Spills liquids when reaching out at the table.

"Normal" changes in vision

1. Reduced ability of lens to accommodate, therefore reading glasses may be needed around age 40+
2. Lens yellows--more light is required
3. Reduced speed in adapting to changes in light/dark
4. Problems with color discrimination
5. Increased numbers of "floaters"
6. Dry eyes
7. Teary eyes

Primary causes of vision loss among elderly persons

1. Cataract - opacity of the lens

   Often described as seeing through a "dirty windshield". Difficult to see detail and color--colors dull.

rehabilitation teachers, O & M instructors. (Staffing varies from clinic to clinic).

Low vision clinics provide optical aids for low vision such as:

1. regular glasses
2. hand-held magnifiers
3. stand magnifiers
4. near telescopes
5. electronic video
6. telescopic lenses
7. prisms

Other aids for low vision - non-optical

1. lighting - direct light, scattered light sources in a room
2. color contrast - between light and dark colors help to see objects against a background.
3. amplification
4. writing devices
5. writing guides
6. labeling devices
7. form
8. sound
9. texture
10. aroma
11. taste

Note: This module can be taught by a guest speaker who is a specialist in low vision, an optometrists or ophthalmologist.

Module Summary

Learning Activities

1. Each CHR will examine low vision devices listed above
2. Each CHR will try on "simulators," various glasses which simulate various eye conditions to get a sense of how one sees with various eye conditions.
3. Each CHR will assess some aspect of the environment as it relates to its suitability for a low vision client. (Consider lighting, colors contrast and discuss ways of adapting the environment at the training site as well as an environment back home.)

Film: Not Without Sight - This 19-minute film demonstrates how an individual sees if he/she has some of the most common eye diseases described above.

Reading Material:

Distribute materials related to Module III.

MODULE III - PSYCHOSOCIAL ASPECTS OF AGING AND VISION LOSS

Objectives

1. To explore the meaning of vision loss to the individual and significant others.
2. To develop sensitivity toward the feelings of the visually impaired person.
3. To gain insight into the changes in relationships which may occur when a family member experiences vision loss.
4. To understand other losses associated with vision loss.
5. To understand the generally accepted reactions to vision loss among the elderly, and the reactions observed and experienced by trainees as they relate to Indian culture.

Expected Outcomes

1. Trainees will be sensitized to feelings about vision loss by the newly visually impaired person.
2. Trainees will be sensitive to family reactions and family members' roles in response to the vision loss of a family member.
3. Trainees will explore their own attitudes toward vision loss.
4. Trainees will explore their own feelings in reaction to working with visually impaired clients.

Losses Associated with Aging and Vision

When older persons use their vision late in life, they may experience the following:

1. Loss of a sense of feeling useful, productive

   Unable to carry out routine tasks or responsibilities including work, household tasks, care for young children or grandchildren, cultural and tribal activities.

2. Loss of independent mobility

   Unable to get around inside the house or outside in the community/reservation.

   Unable to drive a car to keep appointments, shop, visit.

3. Loss of control over environment

   Needing assistance to go from place to place.

   Having to arrange a schedule around others (family members, friends, others).

   Inability to keep up with changes in home or immediate neighborhood.

4. Loss of privacy

   Needing someone to read personal mail.

   Needing assistance in managing finances.

   Needing assistance in the home.

5. Loss of the ability to participate in leisure time activities (individual as well as tribal traditional activities and ceremonies.)

   Reading

   Cooking for family and tribal ceremonies

   Needlework, basketweaving, quilting

   Bingo, cards, watching television, dancing, cultural events (such as pow-wows)

6. Loss of self-confidence

   Feeling less capable than others the same age, other family members, friends, elders who attend the same Nutrition program.

   Feeling different, feeling observed and watched feeling self-conscious.

   Feeling awkward and clumsy when performing everyday tasks such as moving about the indoors and outdoor environment, finding items on the home, including personal items, items for cooking and serving meals, eating.

7. Loss of a social network (friends and opportunities to socialize)

   Friends call or visit less frequently because of their discomfort with vision loss.

   Initiates less contact because of his/her own discomfort.

   Avoids nutrition centers and other group activities because of feelings of discomfort and inadequacy and self consciousness.

8. Loss of financial security

   Lives on fixed income; loss of a regular salary because unable to do the same job as before vision loss.

   May not be able to support a family.

Reactions to Vision Loss

Many elder people have the following reactions when they lose their vision:

1. Fear of:

   Inability to carry out daily activities

   Further physical losses which are common among elders

   Not managing alone and having to make changes in living arrangements

   Further sight loss

   Rejection or avoidance by others

2. Anger toward:

   Higher beings, "Why me?", "Why now?" (Most Indian elders accept vision loss as God's doing, sometimes because of their own ill doing.)

   Family members and friends, because of dependency upon them

3. Mourning:

   For a sense (vision) that has died or is dying

   For the person who was, but now does not feel whole, complete

   The mourning process varies from person to person

4. Denial

   That the vision problem exists--does not want to be different

   That there is a need for help, for eye care

   That there will be further losses

   That he cannot do what he used to

   Of need for help and assistance

5. Magical thinking

   Sight will miraculously return

   Will not need to seek help--will be independent

Will not be different, will be "normal", whole and complete like everyone else

6. Embarrassment and self-consciousness because:

   May not be able to recognize faces

   May not be able to move around independently

   May grope, fumble and stumble

   May make a mess eating in public

   May be considered deaf, retarded, mentally ill by uninformed others

7. Isolation

   Isolates self because of discomfort with self and dealing with other people and the outside world

   Others keep distance, usually due to lack of information and feelings of discomfort about blindness or disability in general.

   Going out may mean getting lost or experiencing some mishap

   Does not want to be dependent on someone else for assistance outside the home.

8. Depression

   Future appears bleak

   "Natural" reaction to above perceived losses

9. Cultural implications of the loss of vision (to be discussed and presented by trainers.)

Module Summary

Learning Activities

Small group discussion of The Impact of Vision Loss on Native American Elders. Trainers discuss: 1) impact on the individual elder as they know it; 2) reactions of family members; 3) how relationships among family members may change. Small group discussion followed by full group discussion.

Role play: Family Situation representing visually impaired elder

Discussion of role play

Film: Aging and Vision: Declarations of Independence - This 17-minute film depicts ways in which numerous older persons adapted to visual impairment and found life to be satisfying and fulfilling.

Reading Materials: Distribute materials related to the Module IV

MODULE IV - WALKING IN A FAMILIAR ENVIRONMENT

Objectives

1. To develop guiding skills.
2. To incorporate the standard Orientation and Mobility (O&M) terms into trainees' understandings and vocabulary.
3. To become sensitized to ways in which visually impaired persons take in information from the environment.
4. To become aware of safety techniques.

Expected Outcomes

1. Trainees will guide a colleague correctly and efficiently.
2. Trainees will guide a colleague to a seat
3. Trainees will be able to define key terms in O&M.
4. Trainees will outline the ways in which visually impaired persons absorb information from the environment.
5. Trainees will teach one mobility skill.
6. Trainees will teach one safety technique

The setting in which this module is taught should include a variety of textures underfoot (carpeting, tile, cement, gravel, grass, etc.); different air currents; different temperatures; a variety of sounds (radio, TV, clock, running water, voices, sirens, automobiles); narrow and wide corridors; stairs; corners; bends; inclines, and doors.

Definitions and Background

Orientation is defined as:

The process of utilizing the remaining senses in establishing one's position and relationship to all other significant objects in one's environment.

Mobility is defined as:

The ability to navigate from one's present position to one's desired position in another part of the environment. Blind persons have traveled over the years using sticks, staffs, canes, barnyard animals and dogs in combination with the use of their other senses.

Orientation and mobility developed as a recognized occupation after WW/II, upon demand from blinded veterans. The use of the long cane (white cane) was refined as a primary travel tool. Concepts of orientation were identified and defined.

Blind persons have access to various travel aids for mobility:

the human guide
the dog guide
the long cane (or white cane)
electronic equipment

Walking in a Familiar Environment

1. Use of the Human Guide

The purpose of the blind person's learning the use of a guide is to make him a responsible and effective traveler with another person, through whom he can pick up the kinds of cues which will assist him to move about effectively.

Following are the procedures for using a guide. The learner is the visually impaired person who will ultimately use the guide, and the procedures describe the relationship which should exist between the learner and the guide.

2. Position

To make contact with the learner, the guide may place his arm in direct contact with the arm of the learner, or the learner may locate the guide's arm by moving the forearm nearest the guide toward him in a horizontal position until contact is made. (This procedure, of course, is least complex if learner and guide are standing side-by-side).

The learner grasps the guide's arm firmly immediately above the elbow.

The learner's thumb is on the outside of the guide's arm, and the fingers are on the inside of the arm.

The learner's arm is flexed at the elbow with the upper arm firmly against the body.

The learner should be positioned one half-step behind, and to the side of, the guide with his shoulder in direct line behind the shoulder of the guide arm.

It is important for the learner to maintain the position of his upper arm as described, especially when turning corners or making turns, to avoid moving beyond the protection of his guide.

3. Going Through Narrow Space

To pass through a narrow space, it is necessary to make the following adaptations in positioning learner and guide.

The guide extends his guide arm back and in behind the back.

The learner responds by extending his arm, placing him one full step directly behind his guide.

When the guide resumes the normal position, the learner will know that the way is clear and he will return to his position, one half-step behind.

While passing through the narrow opening, the learner should make sure that he is a full step behind his guide so as not to step on his heels. This technique can also be used when the learner is uncertain of the guide or his movements, since it offers more protection.

4. Going Through Doors

The procedure for going through a closed door varies with the type of door, and the direction in which the door opens. There are four possible directions in which doors may open: (1) push out toward the right (2) pull in toward the right (3) push out toward the left (4) push in toward the left. For a beginner the procedures are less complex if he is on the side of the guide toward which the door opens. That is, if the door pulls to the left, the learner should be on the left of the guide.

Upon reaching the door, pause (inform the learner regarding the direction in which the door opens). If there are particular characteristics with respect to safety, or if there are some other reasons for doing so, the guide describes the door, and/or orients the learner to the characteristics.

To push out and toward the right (or left): the guide pushes the door with his free hand as he simultaneously indicates to the learner to get behind him, by shifting the guide arm slightly back.

In the course of moving forward, the learner simultaneously brings his free hand to approximately chest height, extends his arm, with the palm facing the door (reaching knob, or metal plate, etc.). If the door is exceptionally heavy, or swinging, or has a rough surface, the learner should extend his arm, and catch the door with his palm.

If the door is to be closed, the learner must locate the knob on the approach side of the door, grasp it, and, to close the door, must step up just beyond the edge of the door, reach around, grasp the opposite knob, and reach back to close the door.

Variation:

To pull in toward the right (or left): the relationship and techniques of learner and guide are the same as above except that it may be necessary for the guide and learner to step back as the door is opened and, of course, the major motion is pull instead of push. In closing the door, the learner locates the knob immediately and pulls the door to a closed position as he moves through with guide. If it is a swinging door, the learner should extend arm from the waist, and catch the door with his palm.

Shifting: should the guide and learner approach a door when the learner is on the side of the guide opposite that side toward which the door opens, the learner should shift to a position directly behind the guide to pass through. To accomplish this, the learner reaches over with his free hand to grasp the guide's arm so as to maintain continuous contact with the guide. Then, dropping the other hand, he steps back and aligns himself behind the guide, catching the door with the hand just freed.

5. Stairs

The procedure for going down stairs with a guide is as follows:

The guide approaches the stairs and stops when his foot makes contact with the edge of the stairs; the learner is one half-step behind.

As the guide moves forward the learner takes half steps until he feels a downward movement of the guide's arm, or the edge of the step.

.The learner should maintain erect posture, with his weight centered upon his heels (essential for safety).

.The learner remains one half-step behind the guide as they proceed down the stairs.

.When the guide reaches the lang his arm will level, indicating the foot of the stairs.

As the learner gains in proficiency, the guide may merely pause before going down the stairway and the pace may be changed more freely. The handrailing may be used, depending upon the physical condition of the learner. On spiral stairways the learner has more space if he is at the widest part of the stairs.

To go upstairs, the procedure is as follows:

- The guide approaches the edge of the stairs and pauses when he reaches the stairs. The learner is one half-step behind.
- The guide steps up; the learner takes a half-step forward to detect the stairs, and then steps up.
- The weight of the learner should be centered on the balls of his feet.
- The learner remains on the stair behind the guide as they proceed.
- At the landing, the guide takes one step forward, then pauses to signal the learner that they are at the top. This helps avoid a "false step" on the part of the learner.
- The learner should be made aware that the leveling of the guide's arm indicates an even surface.

6. Seating

One of the situations in which the assistance of the blind person by an uninformed sighted person is frequently inappropriate, unnecessary and/or cumbersome, is in seating. The primary concerns regarding seating in a chair relate to ascertaining the shape, size and condition of the chair, that the chair is uncluttered and/or vacant, and that it is stable.

From front of chair:

- .The guide brings the learner to within one half-step from the edge of the chair and informs him of the position and proximity of the chair.
- .The learner steps forward to make contact with the chair with his shins.
- .The learner examines the chair by sweeping his hand vertically and horizontally over the back and seat of the chair.
- .The learner squares off with the chair by aligning the backs of his legs against the seat of the chair.
- .The learner can anchor the chair and control his weight either by grasping the arms of the chair or grasping one side of the seat as he sits down.

From back of chair:

- .The guide brings the learner to within one half-step of back of chair and places learner's hand on back of chair.
- .The learner reaches around, with free hand, to ascertain that chair is vacant.
- .Maintaining hold on the back of chair, learner moves to the front of the chair by following the side of the chair.
- .The learner squares off with the chair by aligning backs of legs against the seat of the chair.
- .The learner can anchor the chair by his grasp of back of chair, as he seats himself.

7. Walking Without a Guide

It is important for the visually impaired person to be able to move about independently in a familiar indoor environment without stumbling, knocking over objects, or injuring himself. More specifically, the learner will need to develop techniques to follow a guideline, walk a straight line, to take in information regarding what is ahead, and to protect himself.

Use of Verbal Directions

Always give directions as clearly and specifically as possible in terms of LEFT and RIGHT or north, south, east or west according to the way the client is facing. When orienting a client to new surroundings, describe the area in as much detail as possible while thinking about moving safely in the environment.

The technique for following a guideline is trailing; for aligning oneself to walk a straight line is direction taking and/or squaring off; for taking in information and protection, upper and lower forearm technique.

Trailing

- The learner extends the arm nearest the wall (or the object to be followed), waist high, toward the wall, with wrist bent at a 45-degree angle.
- The hand moves toward the wall, fingers curled into palm and with the back of little finger and ring finger, makes contact with the wall.
- The learner walks along maintaining contact with the wall.

Direction Taking

The learner reaches his/her objective by getting a line or course from an object or sound.

Squaring Off

The learner stands squarely against, or next to, a wall or an object to acquire direction to move forward in a straight line.

Protective Techniques

There are ways in which the blind person can prevent or reduce the impact of bumping into objects as he moves about the home.

Upper Hand and Forearm Technique

- The arm extends forward to shoulder height and moves diagonally across the chest.
- The palm faces away from the body with fingertips aligned with opposite shoulder.

It is important to maintain an extended arm--diagonally--to provide proper body coverage.

Lower Hand and Forearm Technique

- The arm extends downward, diagonally across the body.

The palm faces the body and the backs of the fingers can make contact with an object which may be in the waistline area.

Room Familiarization

In order to become familiar with a room, its size and what is in it:

establish a point of reference (the door).

To acquire direction, square off in the doorway by making contact with both sides of doorway with backs of hands.

The guide describes the type of room and, in clockwise sequence, identifies the landmarks along the walls.

The relationship of each item to the door is emphasized.

The learner uses trailing and other techniques to explore the room.

8. Locating Dropped Objects

A common problem for a blind person is the location of an object which falls to the floor. Following are suggestions to deal with this:

By the sound, note the direction in which the item falls.

Immediately turn to face toward the sound.

Descend by use of a deep knee bend.

If it is necessary at any time to bend at the waist, the head should be protected by a modified upper hand and forearm technique by bringing the elbow down and in from of the chest and by placing the hand directly in front of the face, to precede safely in space. To search for the object, move the hand in concentric circles from a small to a large circle in the area where the object should be, or scan vertically and/or horizontally.

If the object is not located by the preceding method, pivot 90 degrees to either side and repeat the search patterns. If the object rolls when it is dropped, turn toward the direction of the sound, wait until it stops, and walk to that area.

Rise slowly and cautiously from search position when the object is found.

9. Entering/Leaving a Car

It is desirable for a blind person to be able to enter and leave an automobile as efficiently, safely and gracefully as possible.

To locate the car

Use human guide technique, with verbal description by guide, plus sensory motor cues.

It is important to establish the relationship of the learner to the car, that is, is he facing the front, the back, or the side, and his position with respect to the point of entry into the car.

To establish position in relation to the car

If the guide has not taken the learner directly to the door handle, the learner, after establishing his position in relationship to the car by the aforementioned methods, locates it by trailing to the windshield, passing the side window and dropping his hand straight down from the back of the window.

To enter the car:

- Learner reaches the door handle by trailing technique (unless guide takes him directly)
- Learner opens the door
- He goes around the door, and places hand above open door frame

.He brings hand down to check the seat

.He sits on the end of the car seat, feet outside of the car

.He swings feet into car by swivel motion

.He then ascertains that no part of clothing or possessions extend outside of car

.He verbalizes that the door is to be closed and does so by using the handle

.It is important that the door handle and window handle have been clearly differentiated from each other.

To leave the car:

.Wait for the car to come to a complete stop

.Open the door

.Pivot to swing legs out of the car

.Place hand overhead at top of the door

.Step out of the car

.State door is to be closed, and close door.

A blind person may prefer to enter a car by placing leg nearest car into car, and sliding in sideways, rather than following the "feet outside, then swivel in" technique.

Module Summary

Learning Activities

1. Trainers will work in pairs to learn and teach each technique to each other,

   .under blindfold

   .with the use of simulators

2. Group discussion

Trainees will share their learning experiences under blindfold and simulators

Trainees will give feedback to the other member of the pair regarding his/her skills, verbal cues, technique and what should have been done differently

3. After session learning activity

Trainees will work in teams to continue practicing their teaching techniques related to guiding and giving verbal cues.

Reading Materials: Distribute materials related to the first half of Module V.

MODULE V - DAILY LIVING SKILLS

Objectives

1. To become familiar with the adaptations which blind/visually impaired persons make in carrying out the basic skills of daily living.
2. To develop skills in performing the basic activities of daily living in simulated conditions.
3. To learn to teach the skills to a blind or visually impaired person through simulation exercises.
4. To transfer the knowledge/skill into the American Indian culture and activities of tribal life.

Expected Outcomes

Trainees will develop methods of teaching basic skills of daily living to blind and visually impaired persons in the following areas:

1. Personal Management
2. Sewing
3. Money Identification
4. Communication
5. Household Management
6. Kitchen Tasks
7. Eating Techniques

Daily Living Skills Methods and Adaptations

Descriptions of the methods/adaptations for carrying out daily living skills by blind and visually impaired persons are found in the following pages of Module V.

The trainees will learn to perform and to teach the skills at six practice stations at which they will work in pairs.

Eating skills will be taught/learned at group meals during the training.

All learning activities will be performed under a blindfold or low vision simulators.

The specific activities of daily living are the common activities carried out from morning to night and are taught so that the blind or visually impaired person has the sense of being about to do basic activities independently.

Practice Stations

The trainees will work in pairs at practice stations, at which they will instruct each other in role play teaching/learning situations. The objectives of each station and the materials which will be required follow.

Objectives

1. Objectives of practice station 1

To develop safe and efficient methods of peeling, slicing and dicing vegetables (fruit).

To determine when the task is completed appropriately.

To develop methods of teaching the skills.

2. Objectives of practice 2

To develop a method of spreading appropriately.

To successfully pour cold liquids into a container, in sufficient quantity, without spilling.

To develop methods of teaching the skills.

3. Objectives of practice station 3

To become familiar with adapted sewing aids (needles, tape measures, etc.).

To thread various types of needles

To use various needles threaders

To sew a button

To make a hem

To develop methods of teaching sewing.

4. Objectives of practice station 4

To become familiar with the various adapted communication aids for persons with low vision.

To develop methods of teaching their use.

5. Objectives of practice station 5

To become familiar with the various adapted communication aids for persons who are totally blind.

To develop methods of teaching their use.

6. Objectives of practice station 6

To become familiar with adapted table games.

To develop methods of teaching their use.

Practice Station Content and Materials Needed

1. Peeling, slicing, dicing

   Materials: potatoes, carrots, water, cutting boards, knives, peelers, bowls, paper towels

2. Pouring, spreading

   Materials: pitchers (various sizes), glasses, cups, spreaders, plates, bread, jelly, peanut butter, water, paper towels

3. Sewing

   Materials: needles (plain and self-threading, thread, threaders, scissors, marked tape measures, cloth, buttons (various types, pin cushions

4. Low vision communication aids

   Materials: paper (various kinds), pens/pencils (various kinds), large print materials, watches, timers, writing guides, telephone aids, bills, coins

5. Total blindness communication aids

   Materials: cards with braille alphabet, slates and styli, watches, timers, marking/labeling equipment, writing guides, telephone aids, bills, coins

6. Adapted table games

   Materials: large print cards, braille cards, checkers, dominoes, bingo, cribbage, chess, scrabble.

Below are the steps in accomplishing each of the adapted tasks. Those not included in a learning station are discussed in large group discussions during the second day of the teaching of this module.

Personal Management

1. Brushing Teeth and Applying Toothpaste

   .Hold the bristles, upward, between the fingers of one hand

   .Squeeze the toothpaste onto the bristles

   or

   .Squeeze toothpaste into palm, and scoop onto brush

   or

   .Squeeze toothpaste onto teeth--then brush.

2. Applying lipstick

   Stroke lipstick from right corner to center of lips, and from left corner to center of lips; others prefer stroking from center to corner.

3. Shaving

   .Develop a pattern which will cover all parts of the face without unnecessary retracing by the razor.

   .Use the free hand to maintain a check on the quality of the shave and to help keep the razor in proper position against the face.

   .Use the free hand, also, to pull the skin taut in the area being shaved.

- .Pull the skin in the direction which will cause the hair growth to come straight up and run the razor against the grain of the hair to produce a closer shave.
- .To help maintain symmetrical sideburns, the earpieces of glasses worn during shaving may help to indicate the lower tip of the sideburn, or the cheekbone can be used as a point of reference.

Clothing Care

Selecting the appropriate item of clothing may be a problem for the blind or visually impaired person unless some system of identification is used.

1. Clothing identification

Safety pins: small pins, by location or direction, can serve as a color indicator. For example, a horizontal pin under a folded collar of a shirt indicates the color blue, a vertical pin indicates the color green for example. Pairs of socks pinned at the toe may indicate blue while those pinned at the heel indicate brown.

Staples: use in the same way as safety pins, such as in shirttails, on labels sewn in collars, etc.

Buttons: different sizes and shapes of buttons sewn inside the garment indicate different colors.

Iron-on tape: iron-on tape cut into different sizes and shapes and placed on hidden parts of garments.

Other: trimming, texture, style and location also identify garments for easy finding.

2. Clothing organization

Matching outfits: hang matching clothes together on one hanger as a complete outfit. For example, jacket, tie, shirt and pants or blouse, skirt and jacket. This helps to avoid locating individual items.

Color grouping: group clothing together by color. For example, all blue clothing together at one end of the closet and all black clothing at the other end.

Categories: group similar types of clothing together. For example, pants in one part of the closet and shirts in another.

Different types of hangers (wire, wood or plastic) can help identify garments.

Clothing (garment) bags: clothing bags can be used to separate winter clothing from summer clothing.

3. Dresser organization

Separate clothing into similar categories and place the less frequently used clothing in the bottom drawers and the more frequently worn clothing closer to the top. Use separate sides of a drawer for different items--underwear on one side, socks on the other.

Use drawer dividers.

Plastic ice cube trays are excellent for storing and separating small items such as jewelry (earrings, rings, etc.).

Plastic bags: for gloves, hosiery and other small items.

The visually impaired or blind person's daily life is greatly enhanced by order, organization, a system of organizing and labeling items.

Hand Sewing

1. Threading a Needle

    a) Using the metal-loop needle threader, push metal loop through the eye of the needle

    Put thread through the loop

    Pull both loop and thread back through the eye and the needle will be threaded

    b) Using "Calyx-Eye" needle

    The eye is the slit at the top of the needle

    Stretch the thread across the slit end at the top.

    Pull thread into the eye and the needle will be threaded.

    c) Using Spread-eye needle

    The needle is slit along its length

    Thread is inserted into the slit

    Best for coarse thread

    A pin cushion or a bar of soap may help in threading a needle by "anchoring."

2. Sewing a Button

    Locate the point which should be centered beneath the holes in the button

    Mark that point with a straight pin

To secure thread, make 2 or 3 short stitches close to the pin's head

Place button face up on the pin

Hold in position with pad of thumb on face of the button, index finger under button, and remaining finger under fabric

Thumbnail will locate holes, as needed, and guide the needle

Bring needle up through one hole and insert into another

Pull thread through, leaving some space between button and fabric

At the end, wind thread several times around threads between button and fabric

Run the needle and thread several times through that item to fasten the thread.

Marked tape measures are available or a tape measure can be easily marked at home by placing staples at each inch marking.

Money Identification

Coins

1. Coins are identified by size, thickness and/or texture.
2. A dime is the smallest U.S. coin, and has a milled edge.
3. A penny is slightly larger and has a smooth edge.
4. A nickel is larger and thicker than a penny and has a smooth, rimmed edge.

5. A quarter is larger and thicker than a nickel and has a milled edge.

6. A half-dollar is larger than a quarter and has a milled edge.

Bills

The visually impaired person must rely on a sighted person initially to identify the various denominations of bills.

The bills can then be folded in different ways for easy identification.

One dollar bills may be left flat and unfolded.

Five dollar bills may be folded in half from left to right;

Ten dollar bills may be folded in half from top to bottom.

Twenty dollar bills may be folded in half from top to bottom and again from left to right.

The client may establish whichever of the folds feels most useful to him/her as long as a system of identification is established.

Communication Skills

1. Telephone Dialing

   Orientation to rotary dial - learner uses right index finger to locate metal bar between the 1 and 0 holes. Starting from that bar, learner moves finger counterclockwise to the first hole, which is 1.

   A total of five holes are counted.

A small piece of tape or a glue mark is placed at the 5 hole.

When dialing, the 5 hole is used as a starting reference point.

Learner knows that holes above 5 are 1 to 4 and holes below 5 are 6 to 0.

To dial the phone

1. Inform the learner that letters appear in groups of three to a number, except for 1 and 0 and that letters Q and Z are omitted.
2. The learner places first finger (not the thumb) into the first four holes, from little finger in 1 to index finger in 4.
3. From this position, the index finger dials 5.
4. Fingers are placed in last four holes of the phone, from little finger in 0 to index finger in 7.
5. From this position the index finger is also used to dial 6.

Learner listens to the sound of each key as she/he dials. Learner can determine if the correct number was dialed by the sound.

Orientation to push button - the three middle fingers of the dialing hand are used.

The touch tone pad has a total of twelve buttons in four rows of three each.

1-2-3 are in the top row; 4-5-6 are in the second row; 7-8-9 are in the third row, and 0 is in the center of the bottom row.

Learner memorizes the following vertical sequence:

Index finger	1-4-7
Middle finger	2-5-8-0
Ring finger	3-6-9

To use push button phone

1. Inform the learner of the grouping of letters and numbering which are the same as on the dial phone.
2. Use the index, middle and ring finger across the top row (in one, two, three position) as a point of reference.
3. Move down for four, five, six: seven, eight, nine and zero positions.

Since many or most reservations now have push button phones, the latter method is most useful.

2. Library of Congress Talking Book Cassette Player

Blind and visually impaired persons including many older visually impaired persons can enjoy listening to recorded books and other materials when they have too much difficulty reading printed material. The visually impaired person can receive both recorded books on cassettes and the cassette tape recorder at no charge from a local library for the blind and physically handicapped.

The talking book player is a rechargeable battery-operated machine.

The electric cord is plugged into a standard wall outlet to recharge the battery.

A twelve-hour charge will allow the player to work for six hours before it has to be recharged again.

Do not leave the player plugged in for more than twelve hours.

To operate, there are five buttons on the lower lefthand surface of the player.

The functions of the buttons, from left to right, are as follows:

STOP - identified by an X

REWIND - identified by a V shape with the print facing to the left

PLAY - identified by an O. It starts the machine.

FAST FORWARD - identified by a V shape with the point facing to the right. It winds the tape forward.

EJECT - identified by a smooth surface. It is used to open the door of the recorder for insertion or removal of the tape.

Instructions come with the instrument.

3. Use of conventional cassette recorders

Where it becomes difficult to read and write printed messages, the tape recorder can be very useful for recording messages, telephone numbers, addresses, dictating letters, keeping track of appointments and storing recipes and package instructions.

Assistive Writing Devices

4. Signature guide

The signature guide is a rectangular plastic card with a cutout center slot.

The learner feels the size of the space allowed for the signature.

If necessary, a sighted person places the guide on the line where the signature is needed.

Starting from left to right, writing small, the learner stays in the center of the space, using the free hand to guide across the area.

A signature guide can be made from cardboard or another hard form of paper.

Handwriting

Bold-line paper and felt markers are useful for those with low vision.

Letter writing guides, check writing stencils and envelopes addressing guides aid handwriting. They function the same as the signature guide.

Large print materials and taped materials are available.

Braille

Braille is a system of tactual reading writing

Alphabet, numbers and punctuation are formed from combinations of six dots in a "cell".

Writing is possible with a slate and stylus or with a braille writer.

Telling Time

To modify a standard alarm clock for a visually impaired or blind person, remove the glass from the face of the clock so that the time can be read tactually.

Mark numbers 12, 3, 6 and 9 with dots of glue or small pieces of felt or with a product for the blind called Hi marks.

To tell time the learner feels the position of the hour hand and minute hand in relation to the marked numbers. Good sensitivity in the finger tips is needed to distinguish between the numbers just as it is in reading braille. Some older persons have lost sensitivity in the finger tips which may make this difficult.

Braille clocks/watches

1. Braille watches feature spring crystal covers which can be opened for reading by a finger.
2. Usually three dots are set at 12, two at 3, 6 and 9, and single dots at all other hours.

3. The relationship of the hands of the watch and the dots indicates the time.
4. Ordinary time pieces can be adapted by removing the face cover and attaching appropriate identifying markings.

Other timepieces

1. "Talking" clocks announce the times set to be announced, such as the hour, and the alarm can be set.
2. Timers - raised dots and/or large number timers
3. Timepieces with large numbers and good contrast (black, white)
4. Radio, T.V. will give the time at designated intervals.

Household Management

Identifying Household Items

Several methods to identify items are possible.

1. Identifying by location

   Items may be placed on specific shelves or compartments (pears on lowest shelf, peaches on the next shelf of a closet; or, bills in left-hand compartment, receipts in right-hand compartment of a desk).

   Items may be placed in drawers with dividers (cutlery)

2. Identifying by touch

   Size: vegetables may be in small cans and fruit juice may be in large cans for example.

   Shape: A spoon is different from a knife; fresh vegetables are identifiable by shape and smell.

   Weight: Corn flakes are lighter than sugar

__Weight__: Corn flakes are lighter than sugar

__Texture__: A linen towel feels different from a terry cloth towel

3. __Identifying by sound__

   A bottle of vinegar sounds different from a bottle of maple syrup

4. __Identifying by smell__

   The aroma of ammonia is different from the aroma of chlorine bleach

5. __Identification by labels and marks__

   Use of braille labels

   - Write braille onto adhesive plastic
   - Fasten braille notations to container with rubber bands or staples
   - Use aluminum tags indicating color (available from AFB) for clothing identification
   - Write braille directly onto container (envelope)

6. __Other Identification Methods__

   - Use varying numbers of small pieces of tape (one piece on can means corn; two pieces mean beans) for canned goods.
   - Use varying numbers of notches (one notch on spool of thread means white; two notches, black)
   - Pieces of tape cut in different shapes might identify articles which are duplicated but of different color

Safety pins, french knots, staples, raised dots, etc., of varying numbers may be used

7. Cleaning a flat surface

The size and shape of the area to be cleaned will determine the pattern to follow

Divide the surface (actually or mentally) into sections with overlapping boundaries

Use pieces of furniture or permanent fixtures to mark the boundaries

Clean in workable manageable sections

Follow a pattern, working both vertically and horizontally to assure that all areas are cleaned

Kitchen Safety

1. Stove - regulating a flame - pot and pan placement

Place pot or pan on cold stove burner.

Place hands on both sides of the pan with fingers extended to the base.

Tactually compare the amount of space to the left and right of the surface burners and center the pan from side to side.

Reposition the hands and center the pan from front to back.

Placement of the handle is important.

It must never extend over the edge of the stove where it could be bumped but may be placed in the 3 o'clock or 9 o'clock position for safety.

To locate the handle use the front of the stove (if possible) as a stationary cue and trail to locate the handle of the pan.

Use pot holders at all times in handling hot cooking utensils. (Oven mits are particularly helpful for the oven).

A sighted person sets the flame control at a safe flame level.

Burner dials may be marked at simmer, boil.

Knobs may be marked so that the learner will be able to align a mark on the knob with a mark on the stove surface for safe flame level.

2. Oven (gas/electric)

Practice with cold oven and stand in front of open oven door for safety.

Locate the oven rack.

Use oven-mitted hand to trail, locate rack and pull it out.

Set pan on extended rack and check for accurate placement on center of rack.

Gently push rack back into oven and close door. Sighted person will mark temperature at 350 degrees. The oven dial can be marked at settings most commonly used by the individual visually impaired person. Learner will gauge temperature change of 25 degrees by turning control approximately 1/4 of an inch.

Before removing any utensil from the oven, always turn off the temperature control.

Make this a routine part of cooking procedures.

Use oven mitt to tactually locate the rack sides and gently trail with the gloved hands, locate the sides of the pan, and remove it.

3. Open Fire

Identify space where fire is to be built and make a border of small rocks to mark off the area.

Stack small kindling wood such as twigs, pine cones and newspaper in log cabin style (square shape).

Stack large pieces of wood in tepee style on top of kindling.

Use long matchsticks to light fire.

Use long-handled spoons or other utensils to avoid close contact with fire.

Kitchen Skills - Food Preparation

Below are various food preparation skills for safe cooking by the blind or visually impaired person.

1. Vegetable peeler - with peeler in dominant hand, remove carrot skin with peeler, using sweeps from stem end to tip, away from body.

Rinse.

Tactually determine if all skin is removed.

2. Paring

Hold the fruit or vegetable firmly in one hand.

Hold the paring knife so the index finger rests against the back edge of the blade and the other three fingers grip the handle.

Place the thumb against the item being peeled, well in front of the knife blade.

Apply pressure from the forefinger enabling the blade to slide under the peeling toward the thumb.

Remove the peelings in regular strips, holding the knife at a slight angle so that the peelings being removed are as thin as possible.

Turn the object slightly, as necessary, and repeat the process.

Use the tip of the knife to remove spots which are perceptible to the touch.

Immersion in cold water after paring makes blemishes more distinguishable.

A floating-blade peeler with a loop-like handle is a device which may be pulled along the surface of the fruit or vegetable.

3. Cutting, Slicing, Dicing

Cut on a hard wood board which is evenly and solidly placed.

Use a sharp knife.

Position the knife at the angle appropriate to the item being cut.

Use the free hand as a guide.

The forefinger of the free hand can be used to measure the thickness desired.

Place the knife at the tip of the finger.

Hold the knife straight, apply pressure with smooth movement and even tension.

To dice, place food cut into even strips on flat surface.

Without separating the strips, turn the slices sideways and cut at evenly spaced intervals across the strips.

A rounded fruit or vegetable (apple, potato) can be stabilized by cutting off enough to make one side flat.

4. Spreading

Semi-solids, such as peanut butter or creamed cheese: place small quantities of the spread at intervals around a slice of bread.

Spread toward the center, using light strokes.

Soft substances such as jam, soft butter: apply a sufficient amount of spread in the center.

Spread the substance from the center to the edges.

Check with fingers beside the bread for excess or droppings. ,

5. Pouring cold liquids - practice pouring cold liquids using weight and temperature change to determine when glass is full.

Fill a pitcher with cold water and grasp a glass with thumb and fingers, with pinky supporting the bottom of the glass, and note the weight.

With the glass in one hand and the pitcher in the other, the hands will be positioned opposite one another.

The pitcher spout is lined up with the rim of the glass.

Lift the pitcher and place the spout gently over the rim of the glass.

Slowly pour and judge when the glass is full by the change in temperature (cold on fingers as glass fills) and weight of glass (heavier as it fills).

Another method of determining when glass is full is to put tip of index finger inside the top of the glass. When water reaches finger, glass has been filled to proper level.

6. Pouring hot liquids - practice pouring hot liquids using weight and temperature change to determine when cup is full.

Hold a cup in one hand with index finger resting on cup rim.

Learner will position kettle spout slightly above cup rim.

The learner will pour slowly and can judge when cup is full by: a) feeling the steam of the hot liquid on finger, b) feeling the temperature change on outside of cup, c) feeling the weight difference.

Eating Techniques

To Approach the Table:

1. Place one hand on the back of the chair
2. With free hand, scan arms and/or seat of chair to ascertain shape and whether or not the chair is occupied
3. Walk around to the front of the chair, line calves of legs against the front edge, anchor chair by placing one hand on the seat or the back
4. Sit down squarely into the chair, feet flat on the floor, and align self with edge of table.

Exploration of the Place Setting:

1. By running the back of the hands gently along the edge of table, align self with the table.
2. To locate place, with flexed arms and curled fingers, lift hands to top edge of table and move gently toward center of table until contact is made.
3. Using the plate as a point of reference, locate silverware by lateral movement of hands to right and left.
4. A light trailing of bowl, of spoon, blade of knife, tines of fork, indicate the types of silverware at place.

5. With arms flexed and fingers curled, follow right edge of plate, and extending arm and fingers gradually, angle to the right to locate tea cup and/or glass.
6. Follow similar technique with left hand to locate salad plate and bread and butter plate.

Orientation to Contents of the Plate:

1. Using edge of plate as point of reference, approach contents of plate from above with tines of fork in perpendicular position. Insert fork into food at position of 6 o'clock, 9 o'clock, 12 o'clock, and 3 o'clock, identifying food by texture and/or taste.
2. Turn plate to bring meat to 6 o'clock position, particularly if meat is to be cut, or
3. Turn plate so that the "best anchored" food item (such as mashed potatoes) is farthest away. It can serve as a "buffer" in picking up other items (for example, push peas toward the mashed potatoes).

To Cut Meat With a Fork:

1. Use edge of plate as point of reference, locate corner of meat with back of fork
2. Anchor plate with one hand
3. Estimate about an inch inward on piece of meat
4. Using lower edge of fork and extending the forefinger along the upper length of the fork for pressure, cut down into the meat.

To Cut Meat With Knife:

1. With knife, locate edge of meat
2. With other hand, place fork over knife and about one-half inch beyond into the meat
3. Insert tines into meat
4. Using the fork as a point of reference, cut from edge of meat inward from one side, to back, to other side of fork in half-moon pattern; that is, cut around the fork.

To Cut Lettuce Salad:

1. Place fork into the nearest part of the lettuce and cut with knife beyond it
2. Place the fork a step farther and cut beyond that, etc.
3. The pressure of the fork anchors the salad bowl during the cutting
4. To pull fork out of lettuce, anchor lettuce with knife.

To Butter Bread or Roll:

1. In the beginning, it may be necessary for the blind person to hold the whole slice of bread in the palm of his hand, place the butter pad on the center of the slice, and move outward with the knife in all directions, or
2. Using the techniques described in the exploration of the place setting, locate bread and butter plate
3. The edge of the bread and butter plate can be used as a point of reference to find the roll
4. Break the roll. In this process "trailing" can help

locate the butter.

5. Return the other hand to the knife and take the knife to the butter
6. Using knife for exploration of butter, estimate amount wanted, and cut
7. With butter on knife, take knife to bread, put butter on center of bread, and spread.

Condiments:

1. Locate condiments by techniques of exploration beyond the plate and to the right and left in limited areas.
2. Salt can be recognized in that it weighs more. The salt shaker usually has larger perforations. Pepper can be recognized by aroma, by weight, and by smaller perforations.

To Pour Salt and/or Pepper:

1. Locate plate with one hand
2. Hold palm of hand above food with fingers spread out about one-half inch
3. Pour over the back of fingers to ascertain amount of salt used, or
4. Pour salt into palm, and with the other hand take pinches and drop onto the plate.

To Put Sugar Into Beverage:

1. Locate sugar bowl by exploration procedure described earlier

2. Hold sugar bowl in palm of left hand
3. Bring bowl near cup
4. Take teaspoon in right hand, keeping contact with rim of cup with right little finger
5. Bring the bowl to the spoon
6. Lift spoonful of sugar out, using right little finger as a point of reference
7. Put sugar into cup.

Or, for a less experienced person:

1. Put sugar down on right side near cup
2. Anchor sugar bowl with one hand
3. Take sugar with other free hand and bring sugar to cup.

To Pour Cream:

1. Locate cream as described above
2. Bring cream pitcher near the cup
3. Anchor cup by placing spout on rim, using one hand as a guide
4. Tilt pitcher and pour.
5. Sound and time will give information as to amount poured.

Dessert:

1. Using exploration techniques, determine the shape of the dessert dish
2. Dessert cutlery, shape of dish, and temperature can be clues to the nature of the dessert.

To Pass Foods:

1. Take the serving dish in the right hand
2. Transfer to left
3. Hold over plate
4. Locate serving instrument by following rim of serving dish
5. Lift food from serving dish to plate
6. Temperature of the serving dish can help to indicate where the contents are located
7. To take a roll or cookie, locate edge of plate and gently move in to find item.

Cafeteria:

1. Sensation of hot and cold indicates where hot and cold foods are located
2. Aroma and sound can also be clues
3. To place foods on tray, use the edge of tray as a point of reference
4. Arrange as table setting
5. In moving tray along cafeteria line, one hand must "lead" to prevent tray from hitting the one ahead and the other will guide the tray, keeping it against riser
6. Carry tray close to body, chest high, holding both sides at center. Move slowly.
7. Locate chair by making contact with thighs (since hands are holding tray)

8. If feasible, align tray with edge of table and slide toward center, or
9. From above table, lower slowly, ascertaining that place is clear, by extending little finger to table surface ahead of tray, or noting whether bottom of tray makes contact with objects on table
10. To unload tray, if there is space, move tray toward center of table, one tray width, and remove items systematically, or
11. Move tray to one side and remove items systematically
12. To replace dinner plate, slide dinner plate toward center of table, bring free hand back to locate space, and set dessert dish in its place.

To Eat on a Tray:

1. The sides of the tray can be used as points of reference
2. Approach to utensils and food can be from sides or back of the tray
3. Compactness of items must be kept in mind.

Module Summary

Learning Activities

1. Review of each of the learning stations and eating experiences in a large group discussion.
2. Trainees will share their learning experiences in full group discussions and share feedback with their working partner.

3. Trainees will discuss the instructions of each skill as it relates to the activities of their own tribe or community.

This section is best taught by the trainers with the assistant of rehabilitation teachers from the local agency for the blind so that a staff person is available for observation, instruction and discussion at each of the learning stations.

Those tasks which were described but omitted at the learning stations were not taught because of safety issues in instructing blind elders but may be taught and/or discussed by American Indian trainers if deemed staff and appropriate.

Film: Blindness: A Family Matter - a 23-minute film which portrays the interrelationships of family members and their feelings, when visual impairment occurs to a family member.

Client Assessment Form

During discussion at the end of the daily living skills component, distribute the client assessment form and review with trainees to show the areas of concern related to blindness.

Adaptive Non-Optical Aids

Distribute adaptive equipment to CHRs for their use in working with blind and visually impaired elderly clients.

Items distributed during AFB Trainings included:

- a signature guide
- Hi marks
- low vision playing cards
- telephone dial
- double spatula

Reading Materials: Distribute reading materials related to Module VI.

MODULE VI - ADAPTED RECREATION AND LEISURE ACTIVITIES

Objectives

1. To assess the "fit" of Anglo adapted recreational materials within tribal customs and traditions.
2. To develop a "philosophy" of meaningful use of time.
3. To develop strategies for helping clients continue prior interests in leisure, cultural and tribal activities.
4. To identify existing and potential recreational/leisure, cultural/tribal pursuits and resources.

Expected Outcomes

1. Trainees will become sensitized to the concept of recreation/leisure for elderly visually impaired persons.
2. Trainees will apply understandings of visual impairment to performance of activities by clients.
3. Trainees will develop plans for expanding clients' opportunities for recreational, cultural, traditional and tribal pursuits.
4. Using appropriate techniques, and under blindfold or simulators, trainees will teach a colleague one recreational skill (how to play one adapted game).

Adapted Recreation and Leisure Activities

Recreation and leisure include individually expressive discretionary activities which may range from relaxation or diversion to physical involvement, emotional participation and personal development.

Recreation may be solitary or with others. Recreational interests of the blind or visually impaired person may be as varied as those of sighted persons. Activities should be based on the individual's interests, not on preconceived notions of what is "good" for a blind person. While integration with sighted persons may be desirable, some blind/visually impaired persons may feel more comfortable with others who have visual impairments if this situation is present in the community or on the reservation.

It is highly likely that the newly visually impaired person will be able to continue to enjoy most earlier leisure pursuits with little or no adaptations. As with the other aspects of the visually impaired person's life, the feelings which he/she has regarding the visual impairment and its consequences, as well as the realities of his/her circumstances, will be significant factors in the person's approach to resuming activities. Participation and carrying out tribal activity is related to options, opportunities and feelings about one's self perception of other's feelings related to blindness.

Ethnic heritage is important among the elders, and it is possible that the older the individual the less physically active he/she will be. This is not true in all cases of course. However, a seemingly passive person may be mentally/emotionally highly engaged in cultural, traditional and ceremonial activities in particular.

Leisure pursuits can be organized according to the level of physical activity, ranging from high to very low.

High Level Activities include competitive sports and travel. With the use of sound in various ways, adaptations have been made which enable visually impaired persons to participate in several types of ball games. Increasingly, with respect to travel, accommodations are made for persons with impairments. Specialized tours for visually impaired persons and for the elderly are available. Gradually, major tourist sites are becoming accessible to disabled persons.

Medium High Level Activities include exercise, individual sports, visits to cultural museums, gardening, and workshop tasks. Activities such as exercise or individual sports (walking, running, swimming, etc.) may require initial orientation and/or continuing guidance from family and friends, or professional leadership if the activities are a part of a community program.

To garden, boundaries such as rocks or a rope guide can be used to outline the garden and to identify the rows of plants. Agricultural extension offices may assist in selecting appropriate items to plant, preparing the soil, dealing with weeds and harvesting the produce.

If one works in a workshop the work area should be appropriately lighted with overhead and swing arm lamps. Tools can be mounted in sequence, by size, using large print numbers and/or raised dots. Reflective, color contrasting tape or luminous paint can be used for contrast.

Safety glasses and guards should be used for power equipment. Safety goggles and glasses can be obtained with prescription lenses.

Medium Low Level Activities include entertaining, socializing, spectator sports, table games, hobbies, caring for a pet, reading, conversation and attending to mass media. Participation in tribal ceremonies such as pow wows may represent all activity levels.

The individual who has mastered the daily living and orientation and mobility skills, can participate in most of the medium low level activities, given the adapted techniques and aids and appliances which are available. Low vision aids can help those with useful sight; table games have been adapted and require only verbalization of what is taking place; handwork hobbies can be adapted by modifications in size, color, light, or in systematic organization. Caring for a pet requires only that one examine the pet tactually. Resources for reading include large print, records, tapes and volunteers.

Very Low Level Activities include meditating, just "being" and resting.

Service agencies for visually impaired persons and service agencies for elders offer opportunities for leisure activities, as do organizations of visually impaired persons in numerous communities. Those resources will be described in Module VII.

It is important to note that the activities which may be considered "recreational" in one culture may be considered spiritual or ceremonial in another and therefore take on additional meaning and significance to the elder who has been an active participant or leader.

Module Summary

Learning Activities

1. Trainees will work in small groups to create a comprehensive list of culturally relevant leisure activities for older American Indians.
2. In small groups, teams will work on what adaptive techniques would enable blind and visually impaired elders to continue to participate in their favorite leisure activities.
3. Full group discussion: small groups will report to the full group.
4. Role play: the older visually impaired person participating in a leisure activity.

Reading Material: Distribute reading material related to Module VII.

MODULE VII - RESOURCES AND ADVOCACY

Objectives

1. To identify public and private rehabilitation services, educational and aids/appliance resources.
2. To develop strategies for making the resources accessible to visually impaired Indian elders.
3. To become familiar with principles/elements of advocacy.

Expected Outcomes

1. Trainees will develop resource files of national, state and local (public and private) resources related to blindness and visual impairment in his/her geographic region.
2. Trainees will understand the procedures involved in seeking and obtaining rehabilitation services for American Indians.
3. Trainees will be cognizant of the elements of advocacy and practice advocacy techniques to get the services they need for older visually impaired clients.

This module is best taught by a guest speaker from the state agency for the blind in the city in which the training is taking place. Parallels can be drawn to similar services in other states.

Agencies for the Blind

Every state has a public (tax supported) statewide agency for the blind and most states have private, nonprofit agencies for the blind.

The public agency may be a discrete governmental unit such as a State Commission for the Blind or it may be within another state unit such as in the state Rehabilitation Agency or in the Department of Education. The public agency is funded by federal and state monies. State agency headquarters typically are located in the state capitol and regional offices are located in key cities throughout the state. Services generally include: counseling, rehabilitation teaching, orientation and mobility and help in finding employment. Some state agencies have sheltered workshops and/or vending stand programs. The service providers, who work out of the regional offices, go to the residence (or reservation) of the visually impaired person to offer assistance.

State agencies may also have rehabilitation centers which offer comprehensive rehabilitation services. Such services are more concentrated than home services inasmuch as the clients may reside at the center or attend every day, and the rehabilitation team is on the premises. Clients also benefit from contact with their peers (other visually impaired persons) within the center programs.

Of particular interest are the services specifically for the older visually impaired person through Title VII-Part C of the Rehabilitation Act, which provides community-based independent living skills instruction to visually impaired elders in their own homes. Unfortunately, only 28 states have those funds and can provide these services as of 1990.

Private Agencies for the Blind

Private agencies may be found in major cities throughout the state. Their funding comes from donors and, in some cases, from purchase-of-service by the state agency. Instead of governance by statute, the private agency is governed by a Board of Directors composed of local citizens. The types of services vary depending upon the size of the agency, but they typically include: counseling, rehabilitation teaching, orientation and mobility, social work and possibly psychological, psychiatric and recreational services as well as job training and specialized employment. Services may be offered in the home, in the office or in a rehabilitation center. Services are free except in some agencies which have established fees on a sliding scale according to ability to pay.

Low Vision Clinics

A low vision clinic may be within a public or private agency for visually impaired persons, in a hospital, in a school of optometry, or it may be free-standing. The staff of the clinic includes the following personnel: optometrist, ophthalmologist, low vision trainer, other low vision aides and, sometimes, a rehabilitation teacher and/or orientation and mobility instructor. The services of a low vision clinic include diagnostic examinations, prescription of lenses and training in the use of the lenses so as to ensure optimum use. Information is also provided regarding non-optical aids and ways in which to modify the environment so as to enhance existing vision.

Agencies for the Elderly

As in the field of services to visually impaired persons, every state has a statewide Office of Aging (referred to by a variety of names) which is supported by federal and state funds. As in the blindness service system, there are local private agencies and some supported by local tax funds.

To implement programs in the aging system, states are divided into regions called Area Agencies on Aging (AAA's). The AAA is responsible for determining need in that area, encouraging the development of services and allocating funds, provided by the state office, to both public and private service organizations.

Services which may be provided in the elder's residence or at a senior center include: counseling, social work, nutrition programs, transportation, chore services, protective services, health screening and leisure time activities.

The American Foundation for the Blind (AFB)

The AFB works toward helping the two service fields (visual impairment and aging) collaborate so as to ensure that the visually impaired elder receives integrated services to meet his/her needs related to both aging and vision loss. There is evidence that such collaboration is taking place between the two service systems at the state level in certain states as well as at the local level.

AFB is the major resource for information and literature regarding all aspects of blindness and services as well as a supplier of specialized aids and appliances. The Directory of Services, published by AFB, contains names, addresses and functions of all of the agencies for the blind in the United States as well as all of the low vision clinics and professional preparation programs. Consulting services are available regarding all aspects of blindness. AFB, therefore, is a significant support if one is seeking information or assistance regarding visual impairment. In addition to the central office in New York, the AFB has five regional offices in Washington, D.C., Atlanta, Georgia, Chicago, Ohio, San Francisco, California and Dallas, Texas.

"Closer to home", at the state level, the resources are the state agency for the blind (or the state agency on aging) or the nearest regional offices. These would be listed in the AFB directory or in a state service directory or in the telephone book, the United Way directory, or other sources which might be found in a local governmental office or the library.

Advocacy

Given the competition for funding and personnel among service agencies and the competition for assistance among special groups, accessibility to service may not be as free as it may appear in agency organizational plans. Consequently, consumers may need advocates in their behalf. This is particularly true for those who are frail and/or who are outside the mainstream economically and culturally. It behooves the service providers to develop skills of advocacy in order to get needed services for clients.

In an article entitled "Effective Advocacy: How to Be a Winner", Tony Apollini[1] describes four elements of advocacy if one attempts to acquire services for an individual, which can be applied to serving elders.

1. Identify the needs and the service agency which may be responsible for meeting those needs. Determine what can be met by the family (or significant others) and what

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[1] The Exceptional Parent, Feb. 1985, pp. 14-19

will require help from the agency. This action is called targeting.

2. Prepare to work with the service providers in deciding how to meet targeted needs by becoming familiar with the system, knowing your rights and where to acquire information, understanding the application and appeals processes, maintaining a positive attitude and building good relationships with service providers.
3. Influence the decision-makers within the service organization by expressing yourself in a direct, confident, polite manner; have the basic facts about the situation and the records available, if relevant; know with whom you are speaking and, if you are not satisfied, go to the individual at the next higher level of authority.
4. Last, follow up to assure that the service is provided as planned.

Advocacy may take place at another level, related to legislation. Advocates must become informed regarding current and pending legislation. They must become familiar with the process by which legislation is carried out. It is important to determine what other groups or individuals are concerned about the issues, and to cooperate with them in contacting legislators in behalf of clients. Letters, telephone calls and personal contacts are ways in which advocates and clients can make their wishes and needs known.

Module Summary

1. Trainees will identify service organizations in their respective areas which may be of assistance to clients in their caseloads.
2. Trainees will plan strategies for advocacy.
3. Trainees will role play a situation in seeking services requiring strong advocacy skills.

Written Curriculum Review: Administer the written curriculum review at the end of the fourth day of training.

The fifth Day of Training

At the completion of using this curriculum to train community health representatives, on the fifth day, the following activities should take place.

1. Wrap up of the 7-Module Curriculum
2. Questions and Answers for the class
3. Discussion on "Using the Training On the Job"
4. Discussion on "How Learning will be Shared with Other Co-workers"
5. Administer Post Training Attitude Test
6. Administer The Training Program Evaluation
7. Distribute Certificates to Trainees

Four Hour Curriculum

If a trainer is including material from this training into another relevant course, or into basic training, an outline for a 4-Hour Curriculum appears in the Appendix.

APPENDICES

A MODEL CURRICULUM TO TEACH COMMUNITY OUTREACH WORKERS TO TRAIN ELDERLY BLIND AND VISUALLY IMPAIRED AMERICAN INDIANS INDEPENDENT LIVING SKILLS: FOCUS ON FAMILY REHABILITATION

AMERICAN FOUNDATION FOR THE BLIND
National Services in Aging
15 West 16th Street
New York, New York 10011

Module 1 - Day 1 (p.m.)

1. Introductions
    - 1.1 Overview of the AFB training project
    - 1.2 Staff introductions
    - 1.3 CHR introductions
    - 1.4 Introduction to rehabilitation
    - 1.5 Film: What Do You Do When You See a Blind Person?
    - 1.6 CHR Information Forms
    - 1.7 Pre-Training Test

Module 2 - Day 2 (a.m.)

2. Understanding Blindness and Low Vision
    - 2.1 "Normal" changes in vision with age
    - 2.2 Definitions
        - 2.2.1 Visual impairment
        - 2.2.2 Low vision
        - 2.2.3 Legal blindness
        - 2.2.4 Functional blindness
    - 2.3 Leading causes of visual impairment and blindness among elderly persons
        - 2.3.1 Cataracts
        - 2.3.2 Glaucoma
        - 2.3.3 Macular degeneration
        - 2.3.4 Diabetic retinopathy
    - 2.4 Functional implications of diseases of the eye
    - 2.5 Film: Not Without Sight
    - 2.6 Low vision services
    - 2.7 Environmental modifications

Module 3 - Day 2 (p.m.)

3. Walking in a Familiar Environment (Sighted Guide and Other Safety Techniques)
    - 3.1 Brief background
    - 3.2 Definitions
        - 3.2.1 Orientation
        - 3.2.2 Mobility
    - 3.3 Travel aids
        - 3.3.1 Human guide
        - 3.3.2 Dog guide
        - 3.3.3 Cane

- 3.3.4 Electronic equipment
- 3.4 Walking with a human guide
  - 3.4.1 Position
  - 3.4.2 Negotiating narrow spaces
  - 3.4.3 Negotiating stairs
  - 3.4.4 Seating
  - 3.4.5 Entering/leaving a car
- 3.5 Walking without a guide
  - 3.5.1 Trailing
  - 3.5.2 Protective techniques
  - 3.5.3 Sound localization
- 3.6 Room familiarization

Module 4 - Day 2 (p.m.)

4. Psychosocial Aspects of Aging and Vision Loss

Discussion by CHRs concerning:

- 4.1 Losses
- 4.2 Reactions
- 4.3 Attitudes
- 4.4 The family and rehabilitation
- 4.5 Film: Aging and Vision: Declarations of Independence
- 4.6 The elderly visually impaired person as a learner
- 4.7 Principles of instruction

Module 5 - Day 3 (a.m. and p.m. and Day 4 a.m.)

5. Daily Living Skills

- 5.1 Communication skills
  - 5.1.1 Telephone dialing
    - 5.1.1.1 Rotary
    - 5.1.1.2 Push-button
  - 5.1.2 Telling time
    - 5.1.2.1 Clocks and watches
    - 5.1.2.2 Adapted alarm clock
    - 5.1.2.3 Braille watch
  - 5.1.3 Signature guide
  - 5.1.4 Large print
  - 5.1.5 Use of cassette recorder
- 5.2 Personal grooming
  - 5.2.1 Brushing teeth
  - 5.2.2 Shaving
  - 5.2.3 Applying lipstick
- 5.3 Eating skills
  - 5.3.1 Place setting/food location
  - 5.3.2 Cutting food with knife and fork
  - 5.3.3 Using salt and pepper
  - 5.3.4 Spreading

Day 3 - (p.m.)

5.4 Clothing care
5.4.1 Clothing identification
5.4.2 Clothing organization
5.4.3 Adaptive sewing items
5.5 Communication
5.5.1 Braille
5.5.2 Money identification
5.5.2.1 Coins
5.5.2.2 Bills
5.5.3 Large print
5.6 Film: Blindness: A Family Matter

Day 4 - (a.m).

5.7 Household management
5.7.1 Cleaning a surface
5.7.2 Identifying personal and household items
5.7.3 Organization
5.8 Kitchen Safety
5.8.1 Pouring liquids
5.8.2 Use of knives
5.8.3 Centering pots and pans on stove
5.9 Handouts
5.9.1 Rotary and push-button dials
5.9.2 Braille alphabet and numbers card
5.9.3 Sewing kit
5.9.4 Hi Marks
5.9.5 Signature card
5.9.6 Double spatula

Module 6 - Day 4 (p.m.)

6. Adapted Recreation and Leisure Activities
6.1 Recreation activities
6.1.1 Individual
6.1.2 Group
6.2 Adapted games
6.3 Group discussion of cultural activities

Module 7 - Day 4 (p.m.)

7. Knowledge of Resources and Advocacy Skills
7.1 Federal resources
7.2 State resources
7.3 Local resources
7.4 How to gain access to resources
7.5 Advocacy

8. Written Curriculum Review

Day 5 - (a.m.)

9. Wrap-up of 7 Module Curriculum
9.1 Questions and Answers
9.2 Use of training on the job
9.3 How learning will be shared with co-workers
9.4 Post-Training Test
9.5 Training Program Evaluations
9.6 Distribution of Certificates

American Indian Elders:
Policy and Service Delivery
Suggested Readings

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National Organizations

American Foundation for the Blind/Regional Offices
National Society for the Prevention of Blindness
Administration on Aging
Rehabilitation Service Administration
Veterans Administration
Social Security Administration
Indian Services
National Health Organizations

State Organizations

State Services for the Blind
Indian Services
State Services for the Aged
State Office of Rehabilitation
State Health Department
State Agricultural Extension Services

Local Agencies

Services for the Blind

Indian Services
Services for Aged
Low Vision Clinics
Community Centers
Governmental Offices
Private Agencies
Churches
Fraternal Organizations
Library
Aids/Appliance Organizations
Health/Welfare Organizations

Appendix C

A Training Model to Teach Community Outreach Workers to Train Elderly Blind and Visually Impaired American Indians Independent Living Skills: Focus on Family Rehabilitation

KEY WORDS FOR THE SEVEN MODULE CURRICULUM

1. AER or AERBVI - Association for Education and Rehabilitation of the Blind and Visually Impaired. The professional membership organization of the field of blindness for the United States and Canada. Holds international regional and state conferences; conducts legislative activity.

2. AFB - the American Foundation for the Blind is a national, nonprofit organization founded in 1921 to help improve the standards of service for blind and visually impaired people. AFB provides direct assistance and referral services in partnership with over 1,000 specialized agencies as well as public schools, universities, senior centers and businesses. AFB is headquartered in New York City, with regional offices in Atlanta, Chicago, Dallas, San Francisco, New York and Washington, D.C. AFB provides the following services:

    a) Offers schools, agencies and organizations the professional services of national and regional consultants on employment, aging, rehabilitation, orientation and mobility, education, low vision, early childhood and multiple disabilities.

    b) Provides public education about blindness.

    c) Publishes books, pamphlets and periodicals, including the Journal of Visual Impairment and Blindness, the leading professional journal in the field, and AFB NEWS, a quarterly newsletter for general readership.

    d) Houses the National Technology Center whose engineers conduct high technology research development.

    e) Houses the M. C. Migel Memorial Library and Information Center, one of the largest collections of print materials on blindness in the world and the largest circulating library on blindness in the United States.

    f) Records and manufactures over 500 Talking Book titles each year under contract to The Library of Congress.

    g) Conducts technological, education and social research on visual impairment and blindness.

    h) Maintains a governmental relations office in Washington, D. C. to consult on legislative issues and represent AFB before Congress and governmental agencies.

i) Adapts, evaluates, manufactures and sells special aids and products to help blind and visually impaired people.

j) Conducts local, regional and national conferences.

3. Activities of Daily Living - All the things people do every day such as bathing, dressing, cooking, eating, cleaning, washing clothes, shopping, recreation.

4. Adaptive Devices - Devices which enable a blind or visually impaired individual to continue to perform everyday tasks with limited or no vision, i.e. a signature guide, talking clock, script writing guide.

5. Braille - A system of raised dots which enables a blind person to read by touch.

6. Cataract - A cloudiness or opacity in the lens of the eye which results in poor, or no, vision.

7. Clue - An object, sound or smell that provides information for orientation but is not permanent like a landmark.

8. Contrast - Distinct differences between objects or objects and background or areas in environment, with respect to light or color.

9. Diabetic Retinopathy - Blurred vision or blocked vision caused by a disorder of blood vessels in the retina.

10. Direction Taking - The method by which a blind or visually impaired person uses verbal directions given by another person to become oriented and more through an unfamiliar environment.

11. Dog Guide - A specially trained dog to help guide a blind person with instructions from the blind person.

12. Floaters - Small particles consisting of cells or libris which move in the vitreous.

13. Field of Vision - The entire area which can be seen without shifting the gaze or head. (Total field of vision is 180 degrees.)

14. Glaucoma - Loss of vision caused by too much fluid pressure in the eye.

15. Landmark - An object, sound or smell that is always in the same place (a tree, a striking clock, a bakery).

16. Legal Blindness - Visual acuity of 20/200 or less in the better eye, with correction, or visual acuity of more than 20/200 if the field of vision is 20 degrees or less.

17. Light Perception - Ability to distinguish light from dark.

18. Long Cane - A specially constructed cane which a blind person uses as an extension of the sense of touch, to move about independently.

19. Low Vision - A vision loss that causes problems in carrying out activities of daily living but which still allows some visual ability.

20. Low Vision Aids - Special lenses or electronic devices that are more powerful than regular eyeglasses.

21. Macular Degeneration - Gradual loss of fine reading vision, caused by damage to the macula (part of the retina).

22. Mobility - The ability to find the way from one's present position to another desired place in the environment.

23. Ophthalmologist - A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who treats diseases of the eye, performs eye surgery and prescribes corrective lenses and medicines for the eye.

24. Optometrist - A Doctor of Optometry (O.D.) who tests the eyes for defects in vision for the purpose of prescribing corrective lenses.

25. Optician - A person who makes corrective lenses as prescribed by an ophthalmologist or optometrist but who does not examine eyes.

26. Optic Nerve - The special nerve of the sense of sight which carries messages from the retina to the brain. (If the optic nerve is damaged vision is lost and the condition is irreversible.)

27. Optic Atrophy - Degeneration of the optic nerve tissue which carries messages from the retina to the brain about what is seen.

28. Orientation - The use of all senses to determine one's position and relationship to significant objects in the environment (the ability to know where one is in the environment).

29. Rehabilitation - The process of helping an individual who has an impairment to make the best use of his/her physical and environmental resources so as to live life as fully as he or she wishes.

30. Rehabilitation Center - A facility which offers rehabilitation services to blind and visually impaired persons including rehabilitation teaching, orientation and mobility, low vision rehabilitation and services, recreation, social work, vocational counseling, etc.

31. Retina - Tissue in the back of the eye which transmits messages to the brain.

32. Room Familiarization - The systematic method by which a blind or visually impaired person becomes familiar with an uncommon physical environment, i.e. a room, its parameter and its contents, in order to move about to locate objects.

33. Sighted (or human) Guide - An individual who guides a blind person, with the blind person grasping his/her arm lightly above the elbow, walking a half step behind the guide.

34. Signature Guide - An adaptive device consisting of a 2 x 3 inch rectangular piece of cardboard or plastic with a narrow opening in the center the size of an average signature; used by a blind or visually impaired person to sign his/her name within the given space. (If signature must be on a line, such as on a form, it may be used with the assistance of a sighted person who places the guide on the line.)

35. Sound Location - A sensory development skill used by a blind or visually impaired person to assess the physical environment.

36. Squaring Off - A term used in orientation and mobility training; to align oneself perpendicular to a wall so that when walking from the wall one can walk at a 90 degree angle.

37. Trailing - The use of the back of the fingers to follow lightly over a straight surface (wall, table, etc.) to locate objects, to move about and to help know where one is.

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

TO BE COMPLETED BY CHR PARTICIPANTS

CHR INFORMATION FORM

Name ______________________________
Job Title ________________________

1. How many people are in your case load? _________

2. How many of the elderly (over 60) in your case load: have poor eyesight _____ or are blind?_________

3. In what settings do you see them?

PLEASE CHECK:

Home ______
Senior Center ______
Nutrition Site ______
Clinic ______
Transportation ______
Other (fill in) ______

4. Have you had any previous training in visual impairment and blindness? Yes____ No____

If so, who provided the training?_______________________________

5. a) What do you think are the main problems of elderly clients who are losing their vision or are blind?

PLEASE LIST:

6. What resources exist in your area for clients who are visually impaired or blind?

____

____

____

____

7. What experience have you had with persons who have trouble seeing or are blind?

____

____

____

8. What do you hope to learn during this training session?

____

____

____

Appendix E

American Indian Rehabilitation Project
Training Native American Trainees
in
Aging and Vision Loss

Pre-Training Test

Name ______________________________ Date __________________
Position __________________________

Directions - Please circle the answer which most clearly represents what you believe to be most accurate for each statement.

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
1) Most legally blind people have some sight.	1	2	3	4
2) Blind people have more acute hearing and sense of touch than sighted people.	1	2	3	4
3) A blind person should not have to meet the same standards as others.	1	2	3	4
4) If I were suddenly blinded, I might wonder if life were worth living.	1	2	3	4
5) Blind people are constantly worried about the future.	1	2	3	4
6) Visually handicapped people see more than they will admit.	1	2	3	4
7) Blindness has little or no effect upon intelligence.	1	2	3	4
8) Blind people yearn for sight more than anything else.	1	2	3	4
9) A blind person is not afraid to express his feelings.	1	2	3	4
10) Blind people need help in carrying out routine activities of living.	1	2	3	4
11) A blind person can never really be happy.	1	2	3	4

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
12) When speaking to a blind person one should first address him by name or touch his arm.	1	2	3	4
13) A blind person can't afford to talk back to people.	1	2	3	4
14) Blind people can be taught to do most of the things they were doing prior to blindness.	1	2	3	4
15) Some sighted people feel a little guilty because they can see and others cannot.	1	2	3	4
16) A blind person standing on a street corner is waiting for someone to take his arm and help him across the street.	1	2	3	4
17) It is possible to know the beauty of the world without sight.	1	2	3	4
18) I might feel uneasy in a social situation with a blind person.	1	2	3	4
19) My attitude toward a blind person would be based more upon his personality than upon the fact that he is blind.	1	2	3	4
20) It is okay to use words such as "look" and "see" when speaking to a blind person.	1	2	3	4
21) It is bitterly degrading for a disabled person to depend so much upon others.	1	2	3	4
22) I might feel uncertain how to act with a blind co-worker.	1	2	3	4
23) Blind people are more easily upset than sighted people.	1	2	3	4

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
24) Blind people are naturally more inward-looking than sighted people.	1	2	3	4
25) Most blind people think and act alike.	1	2	3	4
26) Where I work, or used to work, there is no job above a menial capacity which a blind person could fill.	1	2	3	4
27) There are worse things than being blind.	1	2	3	4
28) Blind people should be given a pension to live on without working.	1	2	3	4
29) Acceptance of blindness is the same thing as acceptance of anything else in life.	1	2	3	4
30) I would feel comfortable working with a blind co-worker.	1	2	3	4
31) The blind adult is not quite as mature or "grown-up" as the sighted adult.	1	2	3	4
32) If a rehabilitation counselor were consulted, there might be a job for a blind person where I work, or used to work.	1	2	3	4
33) Blind people have as many interests as sighted people.	1	2	3	4

34) Imagine that you have received an accidental disability. Mark a different number after each one, putting a 1 after the most severe to you, and continue 2,3,4,5 in order of decreasing severity to you.

Amputation of an arm ______
Deafness ______
Blindness ______
Amputation of a leg ______
Facial burns ______

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT

CLIENT ASSESSMENT FORM

(To be completed at initial interview of client)

Client: Name ______________________________
Address: ______________________________
____
Phone#: ______________________________

Dates of Service: ______________________________
Degree of Vision Loss: ______________________________
Physical Limitations: ______________________________

Independent Living Skills	Can Perform Independently	Can Perform/w Assistance	Cannot Perform but Would Like to Learn	Cannot Perform B Not Ready For Reha
I. HOME MANAGEMENT:				
1. Housecleaning				
Identifying Household and Personal Items				
2. Home Safety				
3. Orientation				
4. Labeling:				
a) Household Items				
b) Clothing				
5. Cooking:				
a) Stove				
b) Oven				
c) Center Pan over Flame				
6. Kitchen Safety				
a) Pouring Cold Liquids				
b) Using Knives				
II. DAILY LIVING:				
1. Money Identification:				
a) Paper				
b) Coin				

BEST COPY AVAILABLE

Independent Living Skills	Can Perform Independently	Can Perform/w Assistance	Cannot Perform But Would Like to Learn	Cannot Perform Not Read For Reha
I. DAILY LIVING (CONT'D):				
2. Clothing Management:				
a) Selection of Appropriate Clothing				
b) Laundering and Care				
(Describe Method Used)				
3. Eating:				
a) Cutting Food				
b) Identifying Food				
4. Personal Care:				
a) Applying Lipstick				
b) Shaving				
c) Applying Toothpaste to Toothbrush				
III. COMMUNICATION:				
1. Writing:				
a) Signature				
2. Phone Dialing:				
a) Rotary				
b) Pushbutton				
3. Telling Time				
(Describe Method Used)				
IV. MOBILITY:				
1. Indoor				
2. Outdoor				
V. MISCELLANEOUS:				
1. Sewing:				
a) Hand				
b) Machine				
2. Medications:				
a) Identification				
b) Organization				

BEST COPY AVAILABLE

ndependent Living Skills	Can Perform Independently	Can Perform/w Assistance	Cannot Perform But Would Like to Learn	Cannot Perform Not Rea For Reh
. MISCELLANEOUS (CONT'D):				
3. Personal Interests:				
a) Hobbies	________	________	________	________
b) Games	________	________	________	________
c) Other	________	________	________	________

I. COMMENTS: ____

____

____

HIS PROJECT WAS MADE POSSIBLE BY A GRANT FROM THE ADMINISTRATION ON AGING.
2/87

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

NAME ______________________________

WRITTEN CURRICULUM REVIEW

1. What is rehabilitation? ______________________________

____

2. List 2 reasons why it is important to involve family members in rehabilitation of the older visually impaired person.

____

____

3. What is legal blindness? ______________________________

____

____

4. List 2 of the leading causes of blindness among the elderly.

____

____

____

5. List 2 types of low vision aids. ______________________________

____

____

____

6. List 3 possible reactions to vision loss among the elderly.

____

____

____

____

7. List 3 ways to use color contrast to help a low vision client in the home.

8. Name 2 aids a blind person may use to get around.

9. Describe the technique of sighted guide.

10. List 3 ways a totally blind person takes in information from the environment.

11. List 3 things to keep in mind as you are teaching an older person.

12. Describe one way in which you would teach a client to use the telephone.

13. How would you instruct a blind person to organize money ($1.00, $5.00 and $10.00 bills)?

14. Describe 1 technique for putting toothpaste on a toothbrush.

15. List 3 ways of identifying clothing.

____

____

____

16. Describe how you would help a blind person know what is on his/her plate.

____

____

17. How would you teach a client to clean a flat surface?

____

____

18. How would you teach a client to pour cold liquids?

____

____

19. Name 4 games which are adapted for the visually impaired.

____

____

____

____

20. List 3 types of agencies which may be helpful in serving a blind client.

____

____

____

21. List 2 points which are important in advocating on behalf of clients.

____

____

____

Appendix H

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

TRAINING PROGRAM EVALUATION

1. Please rate the following parts of the curriculum presented below.

	Very Useful	Useful	Somewhat Useful	Not Usefu
a. Introduction to Rehabilitation	______	______	______	______
b. Family Involvement in Rehabilitation	______	______	______	______
c. Understanding Blindness and Low Vision:				
Definition of Visual Impairment				
Causes of Vision Loss Among the Elderly	______	______	______	______
Low Vision Services and Aids	______	______	______	______
Environmental Modifications	______	______	______	______
d. Psychosocial Aspects of Aging and Vision Loss	______	______	______	______
e. Walking in Familiar Environment:	______	______	______	______
Travel Aids	______	______	______	______
Walking with a Human Guide	______	______	______	______
Walking without a Guide	______	______	______	______
Room Familiarization	______	______	______	______
f. Daily Living Skills:				
Communication Skills				
Telephone Dialing	______	______	______	______
Telling Time	______	______	______	______
Signature Guide	______	______	______	______
Money Identification	______	______	______	______
Personal Grooming				
Shaving	______	______	______	______
Applying Toothpaste to Toothbrush	______	______	______	______
Applying Lipstick	______	______	______	______
Clothing Care				
Clothing Identification	______	______	______	______
Clothing Organization	______	______	______	______
Hand Washing	______	______	______	______
Adaptive Sewing Items	______	______	______	______

f. Daily Living Skills (Cont'd):	Very Useful	Useful	Somewhat Useful	Not Useful
Eating Skills				
Place Setting	____	____	____	____
Cutting Food	____	____	____	____
Using Salt and Pepper	____	____	____	____
Spreading	____	____	____	____
Household Management				
Cleaning	____	____	____	____
Identifying Household and Personal Items	____	____	____	____
Organization	____	____	____	____
Kitchen Safety				
Pouring Liquids	____	____	____	____
Use of Knives	____	____	____	____
Centering Pots and Pans	____	____	____	____
g. Adapted Recreation and Leisure:				
Recreational Activities	____	____	____	____
Adapted Games	____	____	____	____
h. Knowledge of Resources	____	____	____	____
i. Advocacy Skills	____	____	____	____

2. How would you evaluate each of the teaching methods used during training week?

a. Lecture	____	____	____	____
b. Role Playing	____	____	____	____
c. Discussion	____	____	____	____
d. "Hands On" Activities	____	____	____	____
e. Simulation Exercises	____	____	____	____
f. Films	____	____	____	____

3. List 3 ways in which this week-long learning has effected you personally and professionally. Please describe.

1.

2.

3.

Please share any additional comments.

Appendix [illegible]

American Indian Rehabilitation Project
Training Native American Trainees
in
Aging & Vision Loss

Post-Training Test

Name ______________________ Date ______________

Position ______________________

Directions - Please circle the answer which most clearly represents what you believe to be most accurate for each statement.

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
1) Most legally blind people have some sight.	1	2	3	4
2) Blind people have more acute hearing and sense of touch than sighted people.	1	2	3	4
3) A blind person should not have to meet the same standards as others.	1	2	3	4
4) If I were suddenly blinded, I might wonder if life were worth living.	1	2	3	4
5) Blind people are constantly worried about the future.	1	2	3	4
6) Visually handicapped people see more than they will admit.	1	2	3	4
7) Blindness has little or no effect upon intelligence.	1	2	3	4
8) Blind people yearn for sight more than anything else.	1	2	3	4
9) A blind person is not afraid to express his feelings.	1	2	3	4
10) Blind people need help in carrying out routine activities of living.	1	2	3	4
11) A blind person can never really be happy.	1	2	3	4

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
12) When speaking to a blind person, one should first address him by name or touch his arm.	1	2	3	4
13) A blind person can't afford to talk back to people.	1	2	3	4
14) Blind people can be taught to do most of the things they were doing prior to blindness.	1	2	3	4
15) Some sighted people feel a little guilty because they can see and others cannot.	1	2	3	4
16) A blind person standing on a street corner is waiting for someone to take his arm and help him across the street.	1	2	3	4
17) It is possible to know the beauty of the world without sight.	1	2	3	4
18) I might feel uneasy in a social situation with a blind person.	1	2	3	4
19) My attitude toward a blind person would be based more upon his personality than upon the fact that he is blind.	1	2	3	4
20) It is okay to use words such as "look" and "see" when speaking to a blind person.	1	2	3	4
21) It is bitterly degrading for a disabled person to depend so much upon others.	1	2	3	4
22) I might feel uncertain how to act with a blind co-worker.	1	2	3	4
23) Blind people are more easily upset than sighted.	1	2	3	4

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
24) Blind people are naturally more inward-looking than sighted people.	1	2	3	4
25) Most blind people think and act alike.	1	2	3	4
26) Where I work, or used to work, there is no job above a menial capacity which a blind person could fill.	1	2	3	4
27) There are worse things than being blind.	1	2	3	4
28) Blind people should be given a pension to live on without working.	1	2	3	4
29) Acceptance of blindness is the same thing as acceptance of anything else in life.	1	2	3	4
30) I would feel comfortable working with a blind co-worker.	1	2	3	4
31) The blind adult is not quite as mature or "grown-up" as the sighted adult.	1	2	3	4
32) If a rehabilitation counselor were consulted, there might be job for a blind person where I work, or used to work.	1	2	3	4
33) Blind people have as many interests as sighted people.	1	2	3	4

34) Imagine that you have received an accidental disability. Mark a different number after each one, putting a 1 after the most severe to you, and continue 2,3,4,5 in order of decreasing severity to you.

Amputation of an arm _____
Deafness _____
Blindness _____
Amputation of a leg _____
Facial burns _____

AMERICAN FOUNDATION FOR THE BLIND

CHR Training Program

This document certifies that

has successfully completed
the one week training course for CHRs
in "Aging and Vision Loss"
including adaptive techniques in independent living.

Alberta L. Orr
Project Director

Ruth Kaarlela
Rehabilitation Teacher

Date

AMERICAN FOUNDATION FOR THE BLIND
15 WEST 16 STREET
NEW YORK, NEW YORK 10011

CHR Training Program
on Aging and Vision Loss
Among Native American Elders

FOLLOW-UP SURVEY

NAME____

Check the training session you attended:

____ Tulsa, Oklahoma, December 1987
____ Albuquerque, New Mexico, February 1988
____ San Francisco, California, April 1988
____ Albuquerque, New Mexico, June 1988
____ Bismarck, North Dakota, August 1988
____ Oklahoma City, Oklahoma, September 1988
____ Tucson, Arizona, August 1989
____ Portland, Oregon, January 1990

1) Are there visually impaired clients in your caseload whom you were not aware of before the training? Yes ___ No ___

2) How many visually impaired clients are in your caseload? ________

3) How many clients are there in your total caseload? ________

4) Have you talked with visually impaired clients about techniques you learned in the training? Yes ___ No ___

5) With how many clients have you talked? ________

6) Which techniques did you discuss?

____

____

____

____

7) How many clients have you taught? ________

8) Have you taught family members? ________

9) Have you been able to refer any clients to any agencies for the blind and visually impaired in your local area or state?

Yes ___ No ___

10) If yes, to what agency?

____

____

11) Do you know if there is an agency for the visually impaired near where you work?

____

12) Which skills that you learned during training have been most useful to you in your work with clients? Please check.

- Communication Skills
  - Telephone dialing ____
  - Telling time ____
  - Low vision materials ____
  - Using a signature guide ____
- Personal Management
  - Money Identification ____
- Personal Grooming
  - Shaving ____
  - Applying toothpaste to toothbrush ____
  - Applying lipstick ____
- Clothing Care
  - Clothing identification ____
  - Clothing organization ____
- Using Adaptive Sewing Items ____
- Eating Skills
  - Place setting ____
  - Cutting food ____
  - Using salt and pepper ____
  - Spreading ____
- Household Management
  - Cleaning ____
  - Identifying household and personal items ____
  - Labeling ____
- Kitchen Safety
  - Pouring liquids ____
  - Cutting and paring ____
- Environment for Contrast ____

13) Are you using sighted guide when you walk with visually impaired clients? Yes ___ No ___

14) Have you taught sighted guide to your clients so they may use it with others? Yes ___ No ___

15) Have you taught sighted guide to the client's family members or friend? Yes ___ No ___

16) Do you know where low vision services are available near your reservation or in your community? Yes ___ No ___

If yes, where? ______________________________

17) Have you been able to refer any clients to low vision services? Yes ___ No ___

How many clients? ________

18) Have you assisted visually impaired and/or blind clients in developing an adapted, cultural, traditional, recreational or leisure activities? Yes ___ No ___

If yes, describe the activities. ______________________________

____

19) Has any of the information discussed during the psychosocial adjustment to vision loss section of the training been helpful to you in understanding your

a) client's reactions to vision loss? Yes ___ No ___

b) the client's family reactions? Yes ___ No ___

20) Have you used any of the items we gave you to help your client? Yes ___ No ___

Please check.

____ Hi Marks
____ Signature guide
____ Playing cards
____ Telephone dial
____ Double spatula

21) Which reading materials have been useful, if any.

22) If you needed to get assistance from a local agency for the blind, what would you like help with most? List as many areas as you wish:

Thank you for your time in completing this follow-up survey.

This project is made possible by a grant from the Department of Health and Human Services, Administration on Aging.

Appendix L

A TRAINING MODEL TO TEACH COMMUNITY OUTREACH WORKERS TO TRAIN ELDERLY BLIND AND VISUALLY IMPAIRED AMERICAN INDIANS INDEPENDENT LIVING SKILLS: FOCUS ON FAMILY REHABILITATION

CHR FOLLOW-UP INTERVIEW

Reservation Visits

May 21-25, 1990

The following questions were used to structure interviews with CHRs who participated in the AFB training.

1. Describe the composition of your caseload
   children
   elderly, etc.

2. In what settings do you see clients?

3. How many clients are in your caseload?
   individuals and/or families

4. Were you aware of blind or visually impaired clients in your caseload before you came to the training session?
   During the training session?
   By the completion of the training session?

5. After the training, were you able to identify visually impaired clients in your caseload whom you had not previously identified?
   Immediately after you returned to work?
   Over time?

6. How many visually impaired clients have you identified since the training?
   How would you describe their functioning? (Physical, psychological)
   Do they have any other disability or health condition?

7. Have you been able to help a blind or visually impaired client by sharing information or skills learned in the training?

8. Have you been able to also share with family members?

9. What would you say has been more important -- the information you learned or the skills you learned?

10. Have you been able to improve the safety of a blind or visually impaired client?

11. Which skills have been most helpful to your client(s)?

12. In general, which skills do you feel are most helpful for you to know, for your clients, for the type of population you serve?

- Communication Skills
  - Telephone dialing
  - Telling time
  - Low vision materials
  - Using a signature guide
- Personal Management
  - Money identification
- Personal Grooming
  - Shaving
  - Applying toothpaste to toothbrush
  - Applying lipstick
- Clothing Care
  - Clothing identification
  - Clothing organization
- Using Adaptive Sewing Items
- Eating Skills
  - Place setting
  - Cutting food
  - Using salt and pepper
  - Spreading
- Household Management
  - Cleaning
  - Identifying household and personal items
  - Labeling
- Kitchen Safety
  - Pouring liquids
  - Cutting and paring
- Environment for Contrast

These questions are important follow-up information because they help us to know what to emphasize in further teachings, what information to eliminate in the curriculum and what information can be considered optional.

13. Do you remember the sighted guide technique?
Can you demonstrate it to me?
Have you taught it to anyone?
Is it something you think a visually impaired client would find useful? feel comfortable using? teach to others?

14. How would you describe family members' reactions to your instruction with a blind or visually impaired client?
Has teaching them skills helped their response?

15. Do you know the closest agency for the blind in your region?
Have you had any contact with the agency?
Prior to the training?

Since the training?
If so, how would you evaluate the assistance you and/or your client received?

16. Have you used or distributed any of the adapted equipment we distributed at the training session, such as hi-marks?

17. Do you remember the component of the training about the psychosocial adjustment to vision loss?
Was that information useful to you?

18. We are interested in knowing whether or not visual impairment interferes with the American Indian's participation in traditional activities, cultural events, religious celebrations.
Can you tell me what you think from your experience?
Can you describe a situation?
Was the curriculum model on adapted leisure activity useful to you?

19. Do you ever refer to any of the reading materials provided during the training?
Where are your reading materials kept?
Do others have access to them?

20. What happened when you returned to your work after the week-long training session?
Did your supervisor inquire about the training?
Did any of your co-workers?
Did you share information with others where you work?
How did you share that information -- make a written report, make a presentation at a staff meeting, provide in-service training, participate in a health fair?

21. Would you say that the training is something you use regularly or is information stored for future reference?

22. What can you say about the training that I can share with others around the country?

Appendix M

The Four-Hour Component For CHR Basic Training

I. Understanding Blindness & Low Vision

1. Incidence & Prevalence

1.2 "Normal" changes in vision

1.3 How the eye functions

1.4 Definitions

1.4.1 Visual impairment

1.4.2 Low Vision

1.4.3 Legal blindness

1.5 Leading causes of visual impairment

1.5.1 Cataracts

1.5.2 Glaucoma

1.5.3 Macular degeneration

1.5.4 diabetic retinopathy

1.6 Functional implications of diseases

1.7 Low vision aids

1.7.1 low vision clinics

1.8 Environmental modifications

Assignment - contrast

II. Walking in a familiar environment

2.1 Definitions

Orientation

Mobility

2.2 Travel Aids

2.2.1 human guide

- 2.2.2 dog guide
- 2.2.3 electronic aide
- 2.2.4 long care

2.3 Walking with a human guide

- Position
- Negotiating narrow spaces
- Negotiating stairs
- Going through doors

2.4 Seating

2.5 Entering/leaving an automobile

2.6 Walking without a guide

- Trailing
- Protective techniques
- Sound localization

2.7 Room familiarization

III. Communication skills/aids -

- Low vision writing aids
- Telephone
- Cassette
- Time pieces

Contrast/large print

V. Community resources-

VI. Eating skills

RK/lb
6/89

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

Tucson, Arizona
July 31 - August 11, 1989

Qualifying Criteria for Trainer Certification

1) Each trainer will prepare a lesson plan for teaching a skill.

   Lesson plan will include:

   - content to be covered
   - teaching method(s)
   - materials required to teach a skill
   - learning activity planned
   - after-session learning activity assignment
   - reading assignment

2) Each trainer will teach a skill area to the professional trainers individually.

3) Each trainer will complete a written qualifying exam.

4) Each trainer will evaluate the training curriculum for cultural relevance and make all necessary modifications, corrections and additions required.

5) Each trainer will teach 2 to 3 components of the curriculum to the class of 30 CHRs, August 7-11, 1989.

6) Each trainer will describe and demonstrate to the class an adaptive technique and its skill instruction. Each will select a skill from a list of 12 skill areas.

7) Each trainer will read an autobiography and be prepared to participate in a discussion regarding the following features of the autobiography:

   a) What was the significance of blindness to the individual?
   b) How did he/she cope?
   c) How did blindness affect relationships with family and significant others?
   d) How satisfactorily do you feel the individual learned to live with his/her visual impairment?
   e) What were the strengths/positive factors and the limitations/negative factors associated with the individual?

Appendix U

TRAINING THE TRAINERS
AMERICAN INDIAN REHABILITATION PROJECT

SKILL AREAS FOR DESCRIPTION AND DEMONSTRATION BY TRAINERS

1. sighted guide - basic technique
   up and down stairs
   negotiating narrow spaces
   locating a seat and setting

2. walking without a guide
   protective techniques
   trailing
   sound localization

3. room familiarization

4. communication skills
   telephone dialing
      rotary
      push button

5. telling time
      clocks and watches
   use of timers

6. eating skills
      place setting / food location on plate
      cutting food
      using salt & pepper

7. pouring liquids
   spreading

8. signature guide, envelope guide, check guide
   writing on a line

9. presentation on horticulture/gardening for blind persons

10. demonstration of the us of his marks

11. instruction on how to adapt a leisure time activity for a blind or visually impaired person

12. clothing identification, care and organization

13. Cleaning a flat surface

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
TRAINING THE TRAINERS

Tucson, Arizona
July 31 - August 11, 1989

TRAINING THE TRAINERS WRITTEN QUALIFYING EXAM

Please respond to the following questions on the separate sheets attached. You will want to be as concise but as detailed as possible to demonstrate the depth of your knowledge and understanding of the issues and skills taught in the course. Feel free to use as much space as you require.

1. Define legal blindness and low vision.
2. List the four common causes of visual impairment among the elderly and describe the functional implications of each.
3. Describe the ways in which rehabilitation of elderly persons is unique as compared to traditional medical treatment or general rehabilitation.
4. Describe the situation of a blind or visually impaired person (one who you are familiar with or might encounter in the future). Include the following factors in your description:
    age
    living situation
    family supports
    symptoms of eye conditions
    changes in daily activities as a result of eye problem
    losses that the older person experience
    family reactions
    what skill instruction will the older person require
    what community resources may be needed
    who might be the link between client and resources
5. Our effort has been to instruct you on the various aspects of the field of blindness and low vision. Would you identify and describe what in this experience made the greatest impact upon your professional understanding.

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

TRAINING PROGRAM EVALUATION

1. Please critique the total experience from your vantage point as a trainer.

2. Please rate the following parts of the curriculum presented below.

	Very Useful	Useful	Somewhat Useful	Not Usefu
a. Introduction to Rehabilitation	____	____	____	____
b. Family Involvement in Rehabilitation	____	____	____	____
c. Understanding Blindness and Low Vision:				
Definition of Visual Impairment				
Causes of Vision Loss Among the Elderly	____	____	____	____
Low Vision Services and Aids	____	____	____	____
Environmental Modifications	____	____	____	____
d. Psychosocial Aspects of Aging and Vision Loss	____	____	____	____
e. Walking in Familiar Environment:	____	____	____	____
Travel Aids	____	____	____	____
Walking with a Human Guide	____	____	____	____
Walking without a Guide	____	____	____	____
Room Familiarization	____	____	____	____
f. Daily Living Skills:				
Communication Skills				
Telephone Dialing	____	____	____	____
Telling Time	____	____	____	____
Signature Guide	____	____	____	____
Money Identification	____	____	____	____
Personal Grooming				
Shaving	____	____	____	____
Applying Toothpaste to Toothbrush	____	____	____	____
Applying Lipstick	____	____	____	____
Clothing Care				
Clothing Identification	____	____	____	____
Clothing Organization	____	____	____	____
Hand Washing	____	____	____	____
Adaptive Sewing Items	____	____	____	____

f. Daily Living Skills (Cont'd):	Very Useful	Useful	Somewhat Useful	Not Usefu
Eating Skills				
Place Setting	____	____	____	____
Cutting Food	____	____	____	____
Using Salt and Pepper	____	____	____	____

Spreading ______ ______ ______ ______

Household Management

Cleaning ______ ______ ______ ______

Identifying Household and Personal Items ______ ______ ______ ______

Organization ______ ______ ______ ______

Kitchen Safety

Pouring Liquids ______ ______ ______ ______

Use of Knives ______ ______ ______ ______

Centering Pots and Pans ______ ______ ______ ______

g. Adapted Recreation and Leisure:

Recreational Activities ______ ______ ______ ______

Adapted Games ______ ______ ______ ______

h. Knowledge of Resources ______ ______ ______ ______

i. Advocacy Skills ______ ______ ______ ______

3. How would you evaluate each of the teaching methods used during training week?

a. Lecture ______ ______ ______ ______

b. Role Playing ______ ______ ______ ______

c. Discussion ______ ______ ______ ______

d. "Hands On" Activities ______ ______ ______ ______

e. Simulation Exercises ______ ______ ______ ______

f. Films ______ ______ ______ ______

4. List 3 ways in which this week-long learning has effected you personally and professionally. Please describe.

1.

2.

3.

Please share any additional comments.

Professionals Certified by the American Foundation for the Blind to Teach the 5-Day Specialty Training on Aging and Vision Loss and Independent Living Skills Training

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514 East Tyler
Stillwater, Oklahoma 74075
918-762-2517

P. J. Overholtzer
P. O. Box 90608
Anchorage, Alaska 99509
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10204 Avenida Serena N.W.
Albuquerque, New Mexico 87114
505-897-0194

Madonna Beard
HCR 89, Box 203
Hermosa, South Dakota 57744
605-255-4239 (home)
605-348-2677 (work)

Cheryl LaPointe
CHR Program - IHS
Room 6A-54
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852
301-443-2500

Professionals Certified to Teach the 4-Hour Component on Aging and Vision Loss Incorporated into CHR Basic Training

Corinne Axelrod
California Rural Indian Health Board
2020 Hurley Way, #155
Sacramento, California 95825
916-929-9761

George H. Lomayesva*
7900 South J. Stock Road
Tucson, Arizona 85746
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Nicky Solomon, Director, Community Health Representative Program, Indian Health Service

Betty White, Chairperson, National Association of Title VI Grantees, Yakima Indian Nation, Area Agency on Aging

Eileen Lajan, Senior Citizens Program, Eight Northern Indians Pueblo Corporation

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Appendix U

Project Tribal and State Representation

During the course of the project, the American Foundation for the Blind has trained community health representatives from the following tribes.

Apache of Oklahoma
Arapaho Tribe of Oklahoma
Blackfeet Tribe of Montana
CRIT
Caddo Tribe of Oklahoma
Cherokee Tribe of Oklahoma
Chickasaw Nation of Oklahoma
Chippewa Tribe of Minnesota
Chitimacha of Louisiana
Choctaw Tribe of Oklahoma
Coeurdalene
Colinelle
Comanche Tribe of Oklahoma
Confederated Tribes of Warm Springs, Washington
Coushatta Tribe of Louisiana
Creek Nation of Oklahoma
Delaware Tribe of Oklahoma
Eastern Band of Cherokee, North Carolina
Fort Hill Apache
Fort Sill Apache of Oklahoma
Havasupai
Hopi
Hualapai
Jicarilla Apache
Kaibab-Paiute
Kickapoo Tribe of Oklahoma
Lummi
Miami Tribe of Oklahoma
Miccosukee Seminole of Florida
Mohawk
Nambe Pueblo
Navajo Nation of Arizona
Navajo Nation of New Mexico
Nez Peroe Tribe of Idaho
Nooksak Tribe of Washington
Northern Cheyenne
Ohama
Oneida
Osage Tribe of Oklahoma
Paiute
Papago Tribe of Arizona
Pascua/Zaui
Passamaquoddy Tribe of Maine
Penobscot
Pequot Tribe of Connecticut
Picuris Pueblo
Pima Maricopa

Pueblo of Acoma
Pueblo of Isleta
Quechan
Quinault
Rosebud Sioux
Sac and Fox of Oklahoma
San Carlos Apache of Arizona
San Felip Pueblo
San Ildefonson Pueblo
San Juan Pueblo
Santa Ana Pueblo
Santa Clara Pueblo
Santee
Santo Domingo Pueblo
Sells of Arizona
Seminole of Oklahoma
Seneca Nation of New York
Shawnee Tribe of Oklahoma
Shoshone Bannock
Sioux Tribe of South Dakota
Southern Ute of Colorado
Taos Pueblo
Tesque Pueblo
Tohono O'odham
Umatilla Tribe of Oregon
Ute Mountain Ute
Wichita Tribe of Oklahoma
Winnebago
Yakima Indian Tribe of Washington
Zia Pueblo
Zuni Pueblo of New Mexico

Community Health Representatives represented the following twenty-seven states.

Alabama
Alaska
Arizona
California
Colorado
Connecticut
Florida
Idaho
Iowa
Louisiana
Maine
Michigan
Minnesota
Mississippi
Montana
Nebraska

Nevada
New Mexico
New York
North Carolina
North Dakota
Oklahoma
Oregon
South Dakota
Tennessee
Washington
Wisconsin

NEWS FOUNDATION FOR THE BLIND
15 WEST 16 ST. · NEW YORK, NY 10011

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FOR IMMEDIATE RELEASE

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AFB LAUNCHES PROGRAM TO ASSIST ELDERLY BLIND AND VISUALLY IMPAIRED AMERICAN INDIANS

NEW YORK -- The American Foundation for the Blind (AFB) has launched a 17-month project to help improve the quality of life for elderly blind and visually impaired American Indians.

The project is entitled "A Training Model to Teach Community Outreach Workers to Train Elderly Blind and Visually Impaired American Indians Independent Living Skills: Focus on Family Rehabilitation." It is being funded by a $200,000 grant from the U.S. Administration on Aging.

"The purpose of the program is to ensure physical and psychological independent functioning and to prevent costly and premature institutionalization," said project director Alberta Orr, AFB's national consultant on aging.

Orr said a rehabilitation training model will be developed for 200 Indian community health representatives who will, in turn, teach 10,000 elderly blind and visually impaired American Indians adaptive independent living techniques. Training is scheduled at five sites around the country, and project coordinators will refine and improve the model based on experiences at these sessions. The model will then be disseminated to local, state, and federal organizations and agencies on aging and blindness as well as to national American Indian organizations.

The first training session was held in Tulsa, OK, in December 1987 and generated a great deal of enthusiasm, according to Jamie Casabianca Hilton, also a national consultant on aging at AFB and director of training for the project. Hilton said the second session is scheduled in Albuquerque, NM, in February and additional sessions are slated in Bismarck, ND, Phoenix, AZ, and San Jose, CA.

The American Foundation for the Blind is a national nonprofit organization that advocates, develops and provides programs and services to help blind and visually impaired people achieve independence with dignity in all sectors of society.

Training Program to Help Blind Native American Elderly

During the daily living module, trainees learn spreading and cutting eating techniques while under a blindfold.

By Fay Hava Jarosh

Native American health care service workers will bring a new knowledge about blindness and visual impairment to the communities they serve, and the blindness field will benefit from new perspectives on working with diverse American cultures—thanks to a unique grant program being funded by the U.S. Administration on Aging.

The project was established by AFB to train 200 Native American Community Health Representatives to teach independent living skills to elderly visually impaired Native Americans.

Community Health Representatives, employees of the federally sponsored Indian Health Service program, work with Native American elderly people in a wide range of health care settings on their reservations and in the community.

The AFB grant program resulted, in part, from earlier efforts by AFB's Southwest and Western regional centers to forge a network between blindness agencies and the Native American social service delivery system. (For related articles, see AFB NEWS, Fall 1986 and AFB NEWS, Fall/Winter 1987).

"Diabetes is a number one health problem in Native American communities, with a correspondingly high rate of blindness and visual impairment," said Nicky Solomon, national director of the Community Health Representatives (CHRs) program. "But limited resources and severe fiscal cuts make it difficult for us to provide comprehensive training and education programs for CHRs in this area." She noted that more than 350 CHRs responded to the initial call for 200 trainees for the AFB program.

From December 1987 to August 1988, one-week educational seminars were conducted in Oklahoma, New Mexico, California, and North Dakota. The training program included presentations on blindness, low vision, and eye diseases; sighted guide techniques; daily living skills; the role of the family in rehabilitation training; psychological aspects of aging and vision loss, and screenings of various AFB educational films.

Serving as the rehabilitation teacher at these training sessions was Ruth Kaarlela, who recently retired as chairperson of the department of blind rehabilitation at Western Michigan University.

Community Health Representatives practice using a check writing guide and other writing and communication aids.

AFB's national consultants on aging Alberta L. Orr and Jamie Casabianca-Hilton, who are project director and director of training for the project, respectively, said, they, too, have learned new things.

"The CHRs represent American Indian tribes from Maine to Florida and Alaska to Southern California, all with diverse languages and cultural beliefs," said Casabianca-Hilton. "We discovered that what is culturally appropriate for one group is not necessarily appropriate for another." She noted that trainers often had to modify components of the program for each training site.

For example, the section on low vision which emphasizes the use of good lighting in the home proved irrelevant to CHRs working with elderly visually impaired Native Americans who live on reservations without electricity.

Orr noted the differences in Native American attitudes about blindness. Among certain tribes, greater emphasis is placed on acceptance of blindness as one's life condition, rather than the expression of feelings of loss or efforts for adjustment.

Tribal Politics

And, according to Orr, tribal politics set the standard for a particular line of thinking and actions. "In order to make the greatest impact on the visually impaired person and his family, it is important to also educate tribal leaders about blindness," she said. "The CHR's success in this capacity will ultimately be determined by their political position on the reservation."

Based on their experience in working with diverse Native American cultures, Orr and Casabianca-Hilton intend to refine the model teaching curriculum for dissemination to organizations and agencies on aging and blindness as well as to national Native American organizations.

Discussions are currently under way to extend the program. An extension, the grant administrators say, will enable them to respond to the demand for more training sessions as well as integrate curriculum content on aging and vision loss into other educational programs offered by the Indian Health Service.

Fitness Conference for Blind People

DALLAS—AFB's Southwest Regional Center reported excellent attendance at a health and fitness conference for blind and visually impaired people in Dallas May 7. The conference was co-sponsored by AFB's Southwest Regional Advisory Board and the Institute for Aerobics Research, founded by Dr. Kenneth Cooper. It featured presentations by Dr. Cooper, author of Aerobics Program for Total Well-Being, and Harry Cordellos, a marathon runner who is blind, who served as honorary chairman of the conference.

THE INSTITUTE FOR AEROBICS RESEARCH DALLAS

Brian Padden of Richardson, TX, observes his 15-year-old son, Chris, during a brief workout at the health & fitness conference for blind and visually impaired people held at the Institute for Aerobic Research in Dallas.

Low Vision Workshop Held in Montana

BILLINGS, MT—More than 125 parents, educators, rehabilitation personnel and eye care professionals attended a low vision workshop held in Billings, MT, May 19-21, according to AFB's Southwest regional director Judy Scott.

Scott and Gayle Watson of the Pennsylvania College of Optometry made a presentation on "The Visually Handicapped Child," and Leslye Piqueras, AFB's national consultant in low vision, discussed "Futuristic Aspects of Low Vision."

The conference, which Scott helped organize, was co-sponsored by the Southwest Regional Center and other agencies and organizations offering services to blind people in Montana.

AFB INVITES NOMINATIONS FOR BEST NARRATORS OF TALKING BOOKS

NEW YORK—AFB is inviting nominations for the 1988 Alexander Scourby Narrator of the Year Award and the Talking Book Hall of Fame.

The Alexander Scourby Award was established in 1986 by AFB in memory of its most popular Talking Book narrator, and the Talking Book Hall of Fame is being established this year to recognize significant lifetime achievement in the narration of Talking Books for blind, visually impaired and physically handicapped people.

All Talking Book readers are eligible to nominate a Talking Book narrator for each award—the Alexander Scourby Narrator of the Year Award and the Talking Book Hall of Fame—which will be presented in December in New York.

To receive a braille/print nominating ballot for the awards, call AFB's toll-free hotline 1-800-232-5463 (New York residents call 212-620-2147). Or, write the name of one narrator for each award on your own ballot and submit it to: American Foundation for the Blind, Department PR, 15 West 16th Street, New York, NY 10011. Nominations must be postmarked no later than October 15, 1988.

Previous recipients are not eligible for the Alexander Scourby Narrator of the Year Award, which was won in 1986 by Bob Askey of Longmont, CO, and in 1987 by Merwin Smith of Denver.

AFB records Talking Books for the National Library Service for the Blind and Physically Handicapped, which administers the program. Anyone in America with a visual or physical disability that prevents reading of conventional print materials is eligible to receive Talking Books and special playback machines free of charge from 160 regional libraries throughout the United States.

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AFB's Professional and Public Education

By Terry Allen

An AFB-sponsored training program uses simulation exercises to train Native American health care workers to teach independent living techniques to visually impaired Native Americans.

November is National Diabetes Month, established to heighten awareness of one of the nation's most troubling, but often overlooked, health problems. The American Diabetes Association reports approximately 11 million Americans have the disease and, unfortunately, half of them don't know it. Diabetes, a metabolic disorder that affects the way the body uses food, is also the leading cause of blindness and visual impairment in the United States. More than 5,000 new cases of blindness will be reported this year as a result of diabetic retinopathy, a disease that damages the blood vessels in the back of the eye. When these blood vessels are damaged, the eye can no longer send a clear picture to the brain. Early detection and treatment of diabetes is crucial to the prevention of blindness or serious visual impairment. For even when diabetic symptoms go unnoticed, damage to the retinas occurs.

Florida Model Task Force on Diabetic Retinopathy

In 1987, a Florida ophthalmologist, frustrated in her attempts to coordinate diabetes and vision loss programs in her area, contacted AFB's Southeast Regional Center in Atlanta to voice her concerns. Regional director Gerda Groff and regional specialist in aging Oralen Catledge investigated the physician's concerns and shared them with staff of the Florida Division of Blind Services and the diabetes consultant of the Florida Health and Rehabilitative Services Chronic Disease Control Unit. All agreed that inadequate education among medical professionals, people with diabetes, and the general public about diabetic retinopathy was indeed a problem.

To combat this problem, AFB pledged $7,500 in start up funds and staff services with the provision that any programs developed be documented for use as a national model. This initiative became the Florida Model Task Force on Diabetic Retinopathy and drew members from over 30 groups involved with blindness and/or diabetes. Coordination of the task force was undertaken by the Florida affiliate of the American Diabetes Association (ADA) as a special project to run from January 1988 until July 1989.

According to Groff, the task force's mission was "to reduce visual impairment and blindness resulting from diabetic retinopathy and to establish awareness of diabetic retinopathy as a major health problem." To do this, the task force adopted the ADA committee structure and established, among others, committees to handle public education, patient education, professional education, and public relations.

The accomplishments of the task force have been noteworthy. Among them:

- Compilation of a "Resource Directory" listing information on all public and private agencies in Florida that provide health care, social or economic assistance.
- Preparation of an informational brochure, "Diabetes and Blindness," which outlines symptoms, diagnostic techniques, and potential treatments for diabetic retinopathy. The brochure was distributed throughout the state in both English and Spanish.
- Development of continuing education programs to ensure that all health care professionals caring for a diabetic patient are aware of the potential for eye complications and know where to turn for services.
- Endorsement by U.S. Senator Lawton Chiles (D-FL), serving as honorary chairman of the task force. Sen. Chiles brought media coverage to special public awareness programs, such as eye screening projects, and participated in radio and television public service announcements to encourage high risk individuals to have periodic eye exams.

"The data currently available is beginning to reflect the impact of the task force," says Catledge, "and indicates that original projections were correct. The Division of Blind Services registration of people with diabetic retinopathy has doubled in the year since the task force began work."

Adds Groff, "Though the initial objectives of the task force have been met, the continued development of a strong network of agencies in Florida will require that task force members continue to work closely together."

A detailed article by Groff, fellow task force member Boe Barrett, and chairperson Priscilla Rogers on the formation and activities of the task force has been accepted for publication in an upcoming edition of AFB's *Journal of Visual Impairment & Blindness*. An information kit prepared by the task force is available by writing Priscilla Rogers, Division of Blind Services, 2540 Executive Center Circle, West, Tallahassee, FL 32399.

Native Americans

Diabetes is a particularly major health problem in the Native American community. In fact, a recent American Indian Health Care Association study among urban Native Americans in Arizona found diabetes to be epidemic. Compared to a U.S. prevalence of 3.4%, 11% of urban Native Americans have diabetes. Further, family history of diabetes, one of the most important factors associated with increased risk for developing the disease, was found in 38.5% of those studied. It is therefore no surprise that Native Americans have a correspondingly high rate of blindness and visual impairment. And there is a critical backlog of cases of Native Americans needing vision services.

In 1987, AFB obtained a $200,000 grant from the U.S. Administration on Aging to establish a 17-month project to address these concerns (see *AFB NEWS, July-September 1988*). Project director Alberta L. Orr and Jamie Casabianca Hilton, AFB's national consultants on aging, along with Ruth Kaarlela, Ph.D., a rehabilitation teacher and retired chairperson of the Department of Blind Rehabilitation and Mobility at Western Michigan University in Kalamazoo, conducted week-long workshops for Native American health care workers, participants in the Indian Health Service's Community Health Representatives (CHRs) program. CHRs work with elderly blind and visually impaired people, on and off reservations.

The sessions, which were conducted in Oklahoma, New Mexico, California, and North Dakota, included presentations on blindness, low vision, and eye diseases, sighted guide techniques, daily living skills, the role of the family in rehabilitation training, adapted recreation, and the psychosocial aspects of aging and vision loss.

"The goal of the program is to train people who serve as community outreach workers to teach independent living techniques to elderly visually impaired Native Americans," says Orr.

To ensure that this unique and successful program continues, AFB received a supplemental grant from the Administration on Aging to conduct a two-week "Train the Trainers" session. Held in Tucson, AZ, in August 1989, eight health educators representing tribes in different regions of the country participated. They, in turn, will provide training for CHRs in their geographic areas. In addition, elements of the AFB program will be incorporated into the training given to all future CHRs.

Nationwide Efforts

For many years AFB has made specially adapted products available to blind and visually impaired people with diabetes through the *Products for People with Vision Problems* catalog. These include special syringes and filling or guiding devices designed to assure delivery of an accurate dose of insulin.

Most recently, engineers in AFB's National Technology Center developed Touch-n-Talk®, a synthetic speech output box that enunciates the messages shown on the LifeScan One Touch® Blood Glucose Monitoring System. This enables a visually impaired person to accurately monitor blood glucose levels independently.

In 1988, AFB made additional services available to visually impaired people with diabetes through the National Task Force on Diabetes and Visual Impairment. The group, comprised of diabetes educators, physicians and nurses, and blindness professionals, shared resources about vision loss associated with diabetes and evaluated consumer products.

As part of this group's efforts, AFB distributed a self-help diabetes management program on audiocassettes. The two-tape set, entitled *Managing Your Diabetes with Vision Impairment* and *American Diabetes Association American*

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